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**Lactation Consultant – Referral form**

Please email this form to [kchft.lactationconsultants@nhs.net](file:///C%3A%5CUsers%5CMary.Vacher%5CAppData%5CLocal%5CMicrosoft%5CWindows%5CTemporary%20Internet%20Files%5CContent.IE5%5C2ZQPA0TF%5Ckchft.lactationconsultants%40nhs.net)

|  |  |
| --- | --- |
| Mother’s name: | Baby’s name: |
| Mother’s age: | Baby’s gestational age: | Age of baby today: |
| Contact number: | Birth weight: | Birth centile: |
| History of breastfeeding Yes/No | Current weight: | Current centile: |
| Mother’s NHS NO | Baby NHS No: |
| Referred by | Contact number (referrer) |
| Referrer’s name: | Date of referral:  |
| Profession:Midwife/GP/Health Visitor/ Breastfeeding Counsellor / Paediatrician/Other | If other name of service |
| Referrers address: |
| Has a feeding assessment been completed and documented in the Red Book YES/NO |

**Reason for Referral**

|  |  |
| --- | --- |
| Difficulty with latch | Yes/No |
| Poor milk supply | Yes/No |
| Sore nipples or other breast problems | Yes/No |
| Slow weight gain | Yes/No |
| Breast refusal | Yes/No |
| Illness/condition | Yes/No |
| Specialist condition e.g. cleft palate | Yes/No |
| Flat or inverted nipples | Yes/No |
| Suspected restricted frenulum | Yes/No |
| Induced lactation or re-lactation | Yes/No |
| Other | Yes/No |
| If other further information required: |

**Additional information**

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