Merced County Multi-Agency
BREASTFEEDING REFERRAL FORM

Referral From: ________________________ MD RD RN LS IBCLC Date: ____________________________

Agency: ________________________________ Referring Agency's Phone:___________________________

Referral To: ____________________________________ FAX: ____________________________________

Mother's Name: ___________________________________ DOB ________________ English / Spanish

Infant's Name: ______________________________ DOB __________________ Birth Wt ____________

Phone #1 ______________________________ Phone #2 ________________________

Problem List - Check all that apply

☐ Suspected Mastitis/plugged ducts
☐ Suspected Thrush
☐ Suspected Reynaud
☐ Blood in breastmilk
☐ Medications/cannabis use
☐ Maternal illness ________________

☐ Milk supply concerns
☐ Latch problems
☐ Sore nipples
☐ Flat/inverted nipples
☐ Engorgement
☐ Peer counseling support

☐ Suspected Tongue-tie / Lip-tie
☐ Weight problem/Current wt:______date:_______
☐ Suspected food sensitivity/allergy
☐ Suspected Jaundice
☐ Red colored urine or crystals
☐ Suspected GERD

☐ Multiples
☐ Cleft lip/palate
☐ Premie (GA_________)
☐ Adoption
☐ Human milk bank information
Other______________________________

Comments (**referring agency**):

Signature:

Action Taken/Comments (**receiving agency**):

Date seen: Signature:

WIC's Breastfeeding Support: (209) 383-4859 Fax (209) 383-0366