HASTINGS PRINCE EDWARD Public Health

Breastfeeding Consultation Referral Form

Date: _____

Personal Information

Fax to: 613-966-4363

Mother: _____ DOB: _____ yyyy/mm/dd

Baby: _____ M / F DOB: _____ yyyy/mm/dd

Birth Weight: _____ Gestational Age: _____

Address: _____ Postal Code: _____

Telephone #: _____ E-mail: _____

Referred By

Name: _____ Agency/Program: _____

Reasons for Referral

- ☐ Latch/suck problems
- ☐ Nipple shield use
- ☐ Nipple/breast pain
- ☐ Milk production concerns
- ☐ Inadequate weight gain
- ☐ Previous breast surgery
- ☐ Baby not satisfied
- ☐ Bottles/formula
- ☐ Needs support

NOTES: _____

Client Informed Consent

I give my permission for this form to be sent to Hastings Prince Edward Public Health so that a Public Health nurse can contact me regarding breastfeeding. I understand that Public Health will keep my information confidential and will only use it for the purpose of assisting me with breastfeeding.

_____ Signature of Client

_____ Date (yyyy/mm/dd)

☐ Verbal consent given

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