

## Referral to Plunket Community Lactation Consultant

### Primary Caregiver's name

Partner/Support's Name:

NHI:

Age:

Address:

Hazards (e.g. dogs, access):

Phone number:

GP:

Wellchild Provider:

Ethnicity:

Maori

Pacific

NZ European

Asian

Other

Parity:

Type of Birth:

Estimated Blood Loss:

Feeding Classification:

### Baby's Name:

Date of Birth:

Baby NHI:

Baby's Ethnicity:

Maori

Pacific

NZ European

Asian

Other

Gestation at birth:

Birth Weight:

Current Weight:

Date Weighed:



## Reasons for referral

### Maternal Issues:

Nipple or breast Anomalies – specify  
Surgery augmentation/reduction  
Nipple pain/ trauma  
Breast pain/ Mastitis and complication  
Insufficient Milk Supply  
Hyperlactation  
Breastmilk feeding/ Expression  
Induced Lactation /Relactation  
Returning to Work  
Medication in Mother's Milk  
Cessation of Breastfeeding  
Medical conditions: GDM/ PCOS/ Others-specify:

### Other (details):

### Baby Issues:

Preterm / Small for Gestational Age  
Latching Difficulties  
Tongue-Tie assessment required  
Jaundice / Breast milk jaundice  
'Colic' / Intolerance / Allergy / Reflux  
Thrush  
Slow Weight Gain / Failure to Thrive  
Twins or More  
Anomalies / Diseases / Disorders  
Other (details)

Description of feeding and/or lactation problem:

Please outline your current breastfeeding plan

Referrer:

Profession:

Phone/Fax:

Address:

Email:

