Breastfeeding Peer Counselor Referral Form

Client Name _____ DOB _____ Phone _____

Address _____

Email _____

Is this client currently on WIC? Yes_____No_____Unknown _____

Infant Name _____Date of Birth _____ Weeks Gestation_____

Delivery Vaginal _____ Cesarean _____ Birthweight _____ Ht _____

Discharge Date from hospital _____ Weight at Discharge _____

Is baby receiving any supplemental formula? Yes___NO___ Formula Name_____

Reason for Referral (Mark all that apply)

WIC Eligible services _____
Breastfeeding Support _____
Latch Difficulty _____
Separation from baby _____
Needing a Pump _____
Weight Follow Up _____
Other _____
_____

Was this client discharged as exclusively breastfeeding? Yes _____ No _____

Referral Source

Name of Facility _____
Address _____ Phone _____
Contact Person _____

The Breastfeeding Peer Counselor in clinic will contact client within 72 hours from referral to follow up. WIC clients are priority and will be contacted first. Thank you for supporting breastfeeding moms in your community.

The Breastfeeding Peer Counselor will make reasonable effort to contact your client. Please, call the Breastfeeding Helpline at 800-445-6175 if your client needs immediate assistance. Thank you for supporting breastfeeding moms in your community.