

# Lactation Referral Form

If mother is newly postpartum, for immediate assistance, please call 412.545.2022 and select option 1 to reach the lactation counselor on call. For all other referrals, please email to [latch@hsipgh.org](mailto:latch@hsipgh.org).



First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Birth Date \_\_\_\_\_ Due Date \_\_\_\_\_

Anticipated Delivery Site \_\_\_\_\_

Phone Number \_\_\_\_\_ Best time to call \_\_\_\_\_

Address \_\_\_\_\_

# Prior Pregnancies \_\_\_\_\_ History of Breastfeeding: Y / N

Is Mother a Healthy Start Participant: Y / N Referred By: \_\_\_\_\_

Does Mother identify as Black/African American: Y / N

If Delivered:

Infant Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Birth Weight \_\_\_\_\_ Current Weight \_\_\_\_\_ Date \_\_\_\_\_

## Reason for Referral

LAtCH (Lactation Assessment Counseling Home) Support Program

Mother/Family interested in learning more about breastfeeding

Sore nipples or other breast problem

Preparing to return to work/school

Difficulty with latch \_\_\_\_\_

Poor Milk Supply \_\_\_\_\_

Other \_\_\_\_\_

Is there a concern about Infant weight: Y / N

Notes regarding referral:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Referred By \_\_\_\_\_ Date \_\_\_\_\_

## Internal Use ONLY

Date(s) Contacted \_\_\_\_\_ Follow up \_\_\_\_\_

Appointment Date & Time \_\_\_\_\_ Counselor \_\_\_\_\_

400 N. Lexington Ave, Pittsburgh, Pa 15208

412.545.2022

[latch@hsipgh.org](mailto:latch@hsipgh.org)  
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