AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

# Community Lactation Consultant Referral

SURNAME: _____ NHI: _____

FIRST NAMES: _____ DOB: _____

**Please ensure you enter the correct patient details**

| | |
|---|---|
| **Referrals to:** | ComLactationservice@adhb.govt.nz<br>*Please download PDF and save in a secure folder. Complete details, then e-mail to above address. After emailing the referral, please delete the PDF from where it was saved.* |
| **URGENT Referrals only:** | Send Text Message to: **021 724 648** or **021 307 635** |

**Date sent:**

Patient Address: _____

_____

_____ Patient Phone number: _____

Interpreter Required: ☐ Yes ☐ No Preferred Language: _____

**Alert:** ☐ Unknown ☐ Allergies ☐ FV ☐ Child protection ☐ MMH ☐ Other: _____

If an Alert exists, provide details: _____

_____

**Hazards:** e.g. Dogs, Building access: _____

_____

**Referred by:**
Designation _____

Name (please print): _____

Phone: _____ Email: _____

**LMC** (if not the Referrer) _____ **Ph** _____

**Is this referral related to:**

☐ Antenatal care **Complete page 1 section 1**

☐ Postnatal care **Complete page 1 section 2 AND the Observations on page 2**

## 1. COMPLETE FOR ANTENATAL REFERRAL ONLY

EDD: _____ PARITY: _____ GRAVIDA: _____

☐ Poor Breastfeeding History (specify): _____

☐ Breast Surgery (specify): _____

☐ Nipple concerns: ☐ Flat ☐ Inverted ☐ Other (specify): _____

☐ Medical concerns: ☐ GDM ☐ PCOS ☐ Other (specify): _____

## 2. COMPLETE FOR POSTNATAL REFERRAL ONLY. FURTHER INFORMATION REQUIRED ON NEXT PAGE.

### MOTHER

**BIRTH DETAILS:**

Parity: _____ Type of birth: _____

Place of Birth: ACH, BCA,

Other (specify): _____

EBL: _____

**BREAST:**

☐ Mastitis ☐ Abscess

☐ Surgery augmentation/reduction

☐ Oversupply ☐ Low supply

☐ Other (specify): _____

**NIPPLES:**

☐ Intact ☐ Inverted ☐ Trauma

☐ Other (specify): _____

**PREVIOUS BREASTFEEDING HISTORY:**

☐ N/A

☐ Poor history (specify): _____

_____

**PREVIOUS MED/OBST HISTORY:**

☐ GDM ☐ PCOS ☐ Others (specify):

_____

_____

### BABY

Please enter baby's details here:

Surname: _____ NHI: _____

First Names: _____ DOB: _____

Gender: ☐ Male ☐ Female

*LC will use this information to print labels if required*

☐ Breastfeeding not established ☐ Latch difficulties

☐ Congenital abnormalities (specify):

☐ SGA/LGA Centile: _____

☐ Pre-term – not under NICU Homecare ☐ Multiples

☐ Poor weight gain ☐ 10% weight loss

☐ Needs tongue-tie assessment

Gestation at birth: _____

Jaundice: ☐ Yes ☐ No SBR if applicable: _____

No. of wet nappies in 24hrs: _____ Urates present: ☐ Yes ☐ No

Colour of stool: _____

**BREASTFEEDING STATUS AT REFERRAL:**

☐ Exclusively ☐ Fully ☐ Partially ☐ Artificially feeding

COMMUNITY LACTATION CONSULTANT REFERRAL

CR0106

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**Community Lactation Consultant Referral**

**MUST ATTACH PATIENT LABEL HERE**

SURNAME: _____ NHI: _____

FIRST NAMES: _____ DOB: _____

**Please ensure you attach the correct visit patient label**

## COMPLETE FOR ALL POST NATAL REFERRALS

### OBSERVATIONS

#### Breastfeeding

☐ Watched a complete feed (please provide description of feed, e.g. nipple pain, milk transfer, duration)

☐ Feeding on one or both breasts at a feed

☐ Breast compression during a breastfeed

#### Pumping

☐ Double pumping with a double electric breast pump after every feed. Minimum of 8 times in 24 hours

☐ Volume of milk expressed per pump session _____ml

☐ Shown how to hand express

☐ Taking galactagogues? ☐ Herbal ☐ Domperidone. Dose: _____ Start date: _____

#### Weight

Birth weight: _____ Current weight: _____ Date weighed: _____

☐ Weight gain/day

Weight history:

☐ Adequate output? Number of wet nappies/24 hours _____

Number of bowel motions/24 hours _____ Colour: _____

#### Supplementary Feeds

☐ Shown how to pace bottle feed

☐ If giving top-ups: Volume EBM _____ ml and Formula _____ ml Frequency: _____

### ADDITIONAL NOTES

| For Official Use: | Date Received: |
|---|---|
| | Appointment made: Date: |