AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

Community Lactation Consultant Referral

MUST ATTACH MOTHER'S LABEL HERE

SURNAME: _____ NHI: _____

FIRST NAMES: _____ DOB: _____

Please ensure you attach the correct patient label

Referrals to:	**ComLactationservice@adhb.govt.nz**
URGENT Referrals only	Send **Text Message** to ***021 724 648*** ***or*** ***021 307 635***

Date faxed:

Patient Address: _____

_____

_____ **Patient Phone number**: _____

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

If an Alert exists, provide details: _____

_____

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

_____

Referred by:

Designation

_____

Name (please print): _____

Phone: _____ Fax: _____ Email: _____

LMC (if not the Referrer) _____ If A/N, EDD _____

Reason for Referral: _____

_____

Woman aware of referral: ☐ Yes

Primary Language Spoken: _____ Interpreter Required: ☐ Yes / ☐ No

MOTHER

BIRTH DETAILS: Parity: Type of birth:

Place of Birth: ACH, BCA, Other – specify EBL:

Type of pain relief used in labour _____

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

Shown how to hand express: ☐ Yes / ☐ No

Does the woman have a breast pump: ☐ Yes / ☐ No

What have you tried already?

BABY

NHI: _____ DOB: _____ M / F

(Baby details: Complete above or attach Baby's label here)

☐ 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: Birth weight:

Current weight: Date weighed:

Weight history:

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

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

COMMUNITY LACTATION CONSULTANT REFERRAL

CR0106