

Fax: 03 357 4372

Office Phone: 03 357 4970 extension 213

Patient Details:

Mother's Name: _____ **Age:** _____
 Address: _____ antenatal postnatal
 Phone Number(s) _____
 Ethnicity: NZ European Maori Pacific Asian Other _____
 Underlying issues (if relevant):

Baby's Name: _____ **Date of Birth:** _____
 Ethnicity: NZ European Maori Pacific Asian Other _____
 Underlying issues (if relevant):

Reasons for Referral:

Maternal Issues:

- Nipple or Breast Anomalies
- Nipple Pain / Trauma
- Mastalgia / Mastitis and complications
- Insufficient Milk Supply
- Hyperlactation
- Breastmilk feeding / Expressing
- Induced Lactation / Relactation
- Returning to Work
- Medication in Mother's Milk
- Cessation of Breastfeeding
- Other (details)

Baby Issues:

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

Date: _____

Referrer: _____

Phone/Fax: _____

Address: _____

Email: _____

Address: _____

Where possible please send Post natal Discharge Summary with this form.