

Fax: 03 357 4372

Office Phone: 03 357 4970 extension 213

Date: _____
Referrer: _____
Phone/Fax: _____
Address: _____

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

Provide mail address if you have not previously provided it to us.

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) [Click here to enter text.](#)

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) [Click here to enter text.](#)

Patient Details:

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

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