Waikato District Health Board

# Lactation consultant service referral

Patient Label

Mother's name: _____

NHI: _____ or patient details DOB: _____ dd/mm/yy

Address: _____

**Mother's phone number:** _____ **Mother's ethnicity:** _____ Trial form

**Send referral for a Hamilton City client to email:** RCC@waikatodhb.health.nz
**or fax:** Waikato DHB Referral Coordination Centre 07 839 8817
**Send referral for a Waikato Rural client (resides outside Hamilton city boundary) to email:** communityreferralcentre@waikatodhb.health.nz

☐ **Urgent** **Date:** _____ dd/mm/yy

**Alert** ☐ Hazards ☐ Allergies ☐ Child protection ☐ Other _____
e.g. dogs, building access - provide details: _____

| | |
|---|---|
| Referred by | Name *(please print)* _____ Phone _____ |
| | Fax _____ Email _____ Signature _____ |
| Designation | LMC *(if not the referrer)* name _____ Phone _____ |
| | GP name _____ |
| | Well Child / Tamariki Ora name _____ |

**Mother aware of referral** ☐ Yes ☐ Gives permission to share information with other health providers

Primary language spoken _____ Interpreter required? ☐ Yes ☐ No

## MOTHER

### HISTORY

**Birth details:** Parity _____ Type of birth _____

IOL _____ Place of birth _____ EBL _____

Type of pain relief used in labour _____

**Previous breastfeeding history**

☐ N/A ☐ Poor history – *specify* _____

**Previous medical/obstetric history**

☐ GDM ☐ PCOS ☐ IVF pregnancy
☐ Smoking ☐ Brief advice to quit given
☐ Thyroid ☐ Anxiety/depression ☐ Medications – *specify*

**Reason for referral**

☐ Nipple or breast anomalies / surgery
☐ Nipple pain / trauma
☐ Mastitis / abscess
☐ Milk supply issues
☐ Hyperlactation
☐ Breastmilk feeding / expressing
☐ Induced lactation / relactation
☐ Cessation of breastfeeding
☐ Medication issues
☐ Antenatal visit

## BABY

Name _____

NHI _____ DOB _____ M / F

Age of baby _____ Ethnicity _____

### HISTORY

Gestation at birth _____ Birth weight _____

Discharge or 6 week weight _____

Current weight _____ Date weighed _____

Weight history _____

Number of wet nappies in 24hrs _____

Urates present ☐ Yes ☐ No

Colour of stool _____ Number per day _____

**Reason for referral**

☐ Pre term / small for gestational age
☐ Latching difficulties
☐ Tongue-tie / ankyloglossia
☐ Jaundice / breast milk jaundice
☐ Colic / intolerance / allergy / reflux
☐ Candida infection / thrush
☐ Slow weight gain / failure to thrive
☐ Multiple birth
☐ Anomalies / diseases / disorders
☐ Unsettled baby
☐ Other _____

**OFFICIAL USE ONLY:** Date received: _____

Appointment made: _____ Date _____