



Livin' The Breast Life, LLC
P: (207) 573-2936
F: (256) 946-8776
mkohls@livinthebreastlife.com
Brewer, ME 04412

IBCLC Referral Form

Primary contact information: (typically pregnant or lactating parent)

Full name: _____

Date of Birth: _____

Sex: _____ Pronouns: _____ (optional)

Parity: G _____ P _____

Gestational age at birth _____ weeks

Preferred method of contact:

Call_Text_Email

History of Breastfeeding: ____ yes ____ no Requesting insurance coverage: ____ yes ____ no

Secondary contact person: (emergency contact)

Full name: _____

Date of Birth: _____

Pronouns: _____ (optional)

Email: _____

Phone: _____

Pregnancy or Baby information:

Estimated Due Date: _____

Last Menstrual Period: _____

Infant name: _____

Date of Birth: _____

Birth Height: _____ Birth Weight: _____

Referred by:

Name: _____

Address: _____

MD/DO, CNM, NP, PA, RN, LPN, OTHER _____

Email: _____

Phone: _____

Recommended number of visits: _____

Reason for referral:

- ☐ Pregnant patient
- ☐ Parent/family is interested in learning more about breastfeeding
- ☐ Latching difficulties
- ☐ Concerns with milk supply
- ☐ Sore nipples or other breast problems
- ☐ Preparing to return to work/school/other separation
- ☐ Other: _____

**URGENT appointment
needed?**
Please call the office at
207-573-2936 to schedule
ASAP

Office use only

Patient ID: _____ Fax received: _____ Date contacted: _____ Date first scheduled: _____