

THE OBSIDIAN MILK COLLECTIVE | Provider Referral for Lactation Care

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PARENT INFORMATION

Parent Name: _____

Date of Birth: _____

Phone: _____

Email: _____

Infant DOB / Estimated Due Date: _____

REASON FOR REFERRAL

- ☐ Prenatal lactation support
- ☐ Latch / feeding concerns
- ☐ Nipple or breast pain
- ☐ Milk supply concerns
- ☐ Pumping support
- ☐ Infant weight gain concerns
- ☐ Supplementation / feeding plan
- ☐ Oral function concerns
- ☐ Premature / medically complex infant
- ☐ Other: _____

REFERRING PROVIDER

Provider Name: _____

Practice / Organization: _____

Phone: _____ **Referral Date:** _____

Would you like a copy of the patient's lactation care plan?

- ☐ Yes ☐ No

If yes, preferred delivery method:

- ☐ Fax ☐ Secure Email

Fax Number or Email Address: _____