Mahinaona Pediatrics LLC - A Breastfeeding Center

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PH: 808-737-4675 E-Fax: 808-379-3517

Referral for Lactation Consultation: Date of referral _____

Name of Physician Referring:_____
(Print) (Sign)

Physician Phone: _____ **Physician Fax:** _____

Reason for referral (check all that apply) - May apply to mother or baby.

___ Neonatal difficulty feeding at the breast (P 92.5)	___ Ankyloglossia (Q 38.1)
___ High arched palate (Q 38.5)	___ Underfeeding of newborn (P 92.3)
___ Slow feeding of newborn (P 92.2)	___ Abnormal weight gain (R 63.5)
___ Reflux symptoms (R 19.8)	___ Fussy infant (R 68.12)
___ Other (please list diagnosis below)	___ Other (please list diagnosis below)

Patient's name _____ DOB: _____

Patient's birth weight _____ Current weight: _____

Mother's name _____

Contact # _____

- Please fax the baby's discharge summary if pertinent.
- By filling out this form, the referring physician is indicating an agreement for this referral to remain in effect as long as a woman continues to breastfeed and requires lactation support or up to 2 years from date of baby's birth.

- We see families for breastfeeding support and will treat medical issues specifically related to lactation. We do not accept patients for general pediatric care.