UTHealth The University of Texas Health Science Center at Houston | The Lactation Foundation

Return form via fax: (713) 839-0683
or encrypted email: LF@uth.tmc.edu

Lactation Consultant Referral Form

Parent Name:	Infant(s) Name:
Parent DOB:	Infant(s) DOB:
Primary Phone #:	Gestation at Birth:
Secondary Phone #:	In NICU: ☐ Yes ☐ No
Date of Referral:	Birth Weight:
Referral Priority: ☐ Urgent ☐ Routine	Most Recent Weight: Date:

Reason for Referral:
Additional Details:

Parent Risk Factors:	**Infant(s) Risk Factors:**
☐ Sore/cracked/bleeding nipples and/or nipple pain	☐ Latch difficulties
☐ Flat or inverted nipples	☐ Excess weight loss or slow weight gain
☐ History of breast surgery	☐ Supplementing ☐ Jaundice
☐ Current or previous difficulties with milk production	☐ Congenital abnormalities
☐ Other:	☐ Other:

☐ **Please Return Report to:**
Send by:
☐ Fax:
☐ Mail:
☐ Encrypted Email:

Name of Referrer:	Primary Clinic or Hospital:
Signature of Referrer:	

2636 S Loop W, Suite 135, Houston, TX 77054 713-500-2800, option 1