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Referral for Lactation/Infant Feeding/OT services

Name of Baby: **DOB:**

Name of Mother:

ICD-10 Code or Diagnosis Name (if applicable):

Referring Physician or Other Provider:

Precautions/Comments/Notes:

Mother:

☐ Nipple pain or damage

☐ Clogged ducts / Mastitis

☐ Pumping

☐ Engorgement

☐ Oversupply

☐ Low Milk Supply

☐ Weaning

☐ Newborn care (IADL)

☐ Self-Care (ADLs)

☐ Back to work transition

Infant:

☐ NICU graduate

☐ **Feeding Difficulties**:

☐ Breast / or needs assistance with transition to breastfeeding

☐ Bottle

☐ Solids

☐ Other:

☐ Slow weight gain

☐ Reflux

☐ requires use of a nipple shield

☐ Tongue tie (ankyloglossia)

☐ Lip tie

☐ Stridor

☐ Cleft lip/palate

☐ Laryngomalacia or Tracheomalacia

☐ Torticollis or other asymmetry

☐ Plagiocephaly, Brachycephaly, or Scaphocephaly (Flat head)

☐ Other: _____

Physician / Other Provider Signature: **Date:**