

**Barnet 0-19 service: Breastfeeding support**

**Referral form**

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| **Referrer’s name** | Click or tap here to enter text. |
| **Designation/ title** | Click or tap here to enter text. |
| **Telephone number** | Click or tap here to enter text. |
| **Email address** | Click or tap here to enter text. |

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| **Mother’s details** | **Baby’s details** |
| **Name** | Click or tap here to enter text. | **Name** | Click or tap here to enter text. |
| **Phone number**  | Click or tap here to enter text. | **Date of birth** | Click or tap here to enter text. |
| **NHS number** | Click or tap here to enter text. | **NHS number** | Click or tap here to enter text. |
| **Address** | Click or tap here to enter text. |  |  |

**Feeding issues (please tick all that apply)**

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| Position and attachment |[ ]  Expressing |[ ]  Milk supply |[ ]  Combined feeding |[ ]
| Mastitis |[ ]  Social |[ ]  Painful nipples |[ ]  Weight gain |[ ]
| Tongue tie |[ ]  Thrush |[ ]  Engorgement |[ ]  Other (please specify below) |[ ]

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| --- |
| Please give a brief history |

Please send completed form to hcp.4barnet@nhs.net