



Connecting oral health and wellness through a lifetime

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Referral for lactation and feeding evaluation

Patient's Name: _____

DOB: _____

Referral Provider: _____

Follow-up date: _____

Diagnosis: _____

Precautions/comments: _____

Pediatric concerns

- Pain with latch
- Bottle difficulty
- Oral ties
- Slow or no weight gain
- Latch difficulty
- Food allergies
- Frequent spit-up
- Gassiness/colic
- Parent request
- Other:

Parent concerns

- Prenatal assessment
- Breast/nipple pain
- Engorgement
- Clogged ducts/mastitis
- Low milk supply
- Oversupply
- Pumping concerns
- Patient request
- Other:

Signature

Date