



WIC In-Home Breastfeeding Support Service Referral

Wake County Human Services Only: Place PAL 1 Label Here

Mother's WCHS MR # _____

Infant's WCHS MR # _____

Date ___ / ___ / ___

Referral Results Requested? Yes ___ No ___

Mother's Name _____ Mother's DOB ___ / ___ / ___

Address _____ City _____ Zip _____

Phone _____

Baby's Name _____ Baby's DOB ___ / ___ / ___

Referral Made by _____ Phone _____

Department _____ Fax _____

___ English Speaking ___ Spanish Speaking ___ Other Language _____

Reason for Referral _____ Sore Nipples ___ Engorgement ___ Trouble with Latch On
 _____ Baby's Weight Loss _____
 _____ Other: _____

WCHS WIC In-Home Breastfeeding Support Service *Referral Results*

Result of Contact: ___ Home visit done on ___ / ___ / ___

Plan for Mother after home visit:

_____ Problem resolved. Mother will be followed via phone contact or PRN home visits.

_____ Breastfeeding support ongoing. Mother will be followed via phone contact or additional PRN visits.

Results other than home visit:

_____ Phone contact/support on ___ / ___ / ___ (Mother declined in-home support)

*Mother given IHBSS contact information to initiate In-Home Breastfeeding Support Service

_____ Could not contact: ___ No phone number ___ No answer as of ___ / ___ / ___

_____ Called and left messages: mother did not return call as of ___ / ___ / ___

_____ Neither mother nor baby certified for WIC

_____ Mother does not live in Wake County (ineligible)

_____ Other: _____

Please Fax To: (919) 212-7558 Attn: WIC Breastfeeding Coordinator