***Poutiri Wellness Centre***

***Assisting Māmā & Whānau across Western BOP***

*35 Commerce Lane, PO Box 148 Te Puke*

*Phone: 07-573 0091*

***Whānau and self-referrals are easy via:***

***Text:*** *027 554 1120*

***Web:***[*www.breastfeedinghelp.org.nz*](http://www.breastfeedinghelp.org.nz)

***Email:***[*mama@poutiri.org*](mailto:mama@poutiri.org)

***Facebook:***[fb.me/MamaMaiaNgaKakano](https://fb.me/MamaMaiaNgaKakano)

**MĀMĀ MAIA COMMUNITY Breastfeeding support SERVICE**

When form is complete please email it to mama@poutiri.org or it can be sent to any of the above options

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Referral details** | | | | | | | |
| **Name of Referrer:** | |  | | | | | |
| **Date of Referral:** | |  | | | | | |
| **Consent obtained for referral:** | | Yes  No | | | | | |
| **Referral to:** | | Lactation Consultant  Kaiawhina Peer Support | | | | | |
| **Mother’s Details** | | | | | | | |
| **Family Name:** |  | | | | **Given Name(s):** | |  |
| **DOB:** |  | | | | **NHI:** | |  |
| **Address:** |  | | | | **Phone:** | |  |
| **Cell:** | |  |
| **Email:** |  | | | | | | |
| **GP:** |  | | | | **LMC:** | |  |
| **Ethnicity:** | Māori  NZ/European  Pacific  Asian  Other | | | | | | |
| **Community Services Card:** | Yes  No | | | | | | |
| **Estimated Date of Delivery (EDD) if pregnant:** | | | |  | | | |
| **Baby NHI:** |  | | | **Baby DOB:** | |  | |
| **Baby Name:** |  | | | **Baby gender:** | |  | |
| Baby's birth weight |  | | |  | |  | |
| **Previous breastfeeding experience** | | | | Yes  No | | | |
| **Any known risks (please specify) e.g. dogs, domestic violence etc.:** | | | | | | | |
| **Reason for Referral:**  Latching difficulties  Nipple pain  Nipple yeast or oral thrush in baby  Suspected tongue tie  Low milk supply | | | Over milk supply  Engorgement  Mastitis  General breastfeeding advice and education  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| **Background/history (parity, relevant obstetric and medical history, meds, birth details):** | | | | | | | |

***Office use only***

|  |  |
| --- | --- |
| **Referral accepted** | **Appointment date and time:** |
| **Name of LC or Kaiawhina:** |  |
| **Referral Declined** | **Reason:** |
| **Referrer Informed:** |  |