Lactation Referral Form

Date:

Referring Provider	Patient
Please fax this referral to Milestones Pediatric & Maternal Nutrition and include patient's insurance information and any relevant lab results and patient encounters. Fax: 919-899-0667	Patient's Name: Patient's DOB: Patient's Phone #:

Diagnosis for Lactation Consultations *(ICD-10 code is required for referrals)*		
P59.9 Neonatal jaundice, unspecified	P92.8 Other feeding problems of newborn	R63.4 Abnormal weight loss
P92.5 Neonatal difficulty in feeding at breast	R62.51 Failure to thrive in child over 28 days old	R63.5 Abnormal weight gain
P92.6 Failure to thrive in newborn	R63.30 Feeding difficulties, unspecified	R63.6 Underweight
O91.03 Infection of nipple associated with lactation	O91.23 Nonpurulent mastitis associated with lactation	O92.4 Hypogalactia
O91.13 Abscess of breast associated with lactation	O92.3 Agalactia	O92.70 Unspecified disorders of lactation
Other: ____		

Specific Service Requested *(required)*	
Goals of Lactation Support:	
Lactation consultation ONLY	Lactation team appointment (RD & IBCLC support)
Other: ____	

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Referring Physician's Signature

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Referring Physician's Name

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Practice Name

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Practice Address