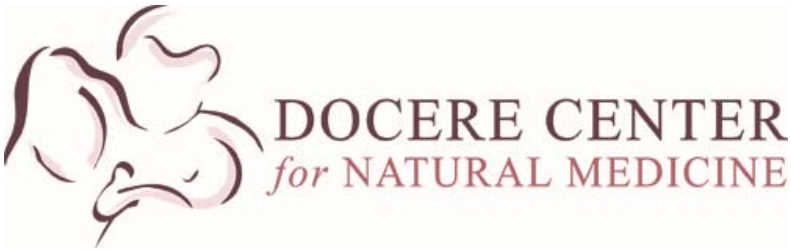



Dear Provider,

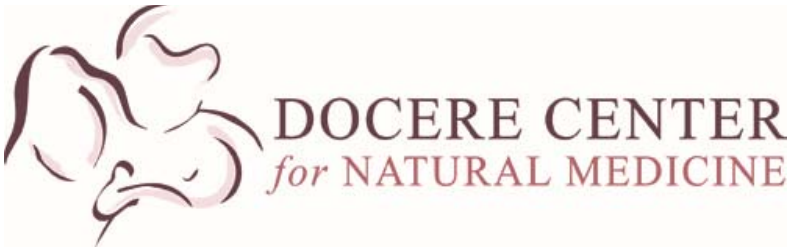
Your patient has expressed interested in scheduling a lactation consultation or breast pump consultation with Renee Beebe, IBCLC or Tessa Vogel, IBCLC at Docere Center for Natural Medicine. The benefits of seeing a board certified lactation consultant are numerous, and allow mom and baby to continue a healthy breastfeeding relationship. Oftentimes, patients come to us because of low milk supply, pain with nursing, inadequate infant weight gain, latch difficulties and other breastfeeding related concerns.

To schedule a lactation visit for mom and baby, a referral is required for both, as we evaluate and treat each individually, in the context of the breastfeeding relationship. If the mom will be seen for a prenatal lactation consultation or a breast pump consultation, the referral is for mom only. For your convenience, a lactation referral form is attached. Please include patient's phone number and a return fax number for yourself, so that we may send records for continuity of care. Your referral is greatly appreciated. You are welcome to contact our office if you require additional assistance.

Sincerely,

Renee Beebe, IBCLC
Tessa Vogel, IBCLC
Chenelle Roberts, ND LM
Krystal Plonski, ND, EAMP
Taylor Summers, ND

6800 E. Greenlake Way N, Ste 250 • Seattle, WA 98115
(p) 206-706-0306• (f) 206-706-4772




# LACTATION AND BREAST PUMP CONSULTATION REFERRAL FORM

Renee Beebe, IBCLC and Tessa Vogel, IBCLC
Chenelle Roberts, ND LM • Krystal Plonski, ND, EAMP • Taylor Summers, ND

**Fax to: 206-706-4772**

☐ Referring BABY

Name: _____

DOB: _____ Sex:_____

SERVICE (CIRCLE):

*Initial Lactation*

CHIEF COMPLAINT:

☐ Feeding problem
☐ Tongue tie
☐ Weight gain
☐ Other: _____

☐ ICD-10: _____

☐ Referring BREASTFEEDING PARENT

Name: _____

DOB: _____ Sex:_____

SERVICE (CIRCLE ONE):

*Initial Lactation; Prenatal Lactation; Breast Pump*

CHIEF COMPLAINT:

☐ Sore nipples
☐ Milk supply
☐ Hypoplasia
☐ Other: _____

☐ ICD-10: _____

*Notes, history, special considerations*: _____

_____

**Number of visits:** ☐ Initial and follow-up x 1 ☐ Initial and follow-up as needed

**INSURANCE**: Include for each patient referred, or attach demographics sheet(s)

Plan name(s): _____

*It is the patient's responsibility to confirm insurance coverage for this visit **beforehand**. Please have patient or guardian **call** Docere Center for billing information and instructions for checking lactation-specific insurance benefits in the outpatient setting.*

**PATIENT PHONE NUMBER**: _____

☐ Call family to schedule ☐ Family will call to schedule ☐ Urgent ☐ Routine

**Referred by**: _____ **Signature**: _____

☐ OB/CNM/LM ☐ Pediatric Provider ☐ PCP ☐ Other: _____

Date of Referral: _____ Please fax visit notes to: _____

Thank you for the opportunity to help care for your patients!

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