Breastfeeding Peer Counselor Client Referral

Today's Date: _____

Staff Name Making the Referral: _____

Clinic Name: _____ Region: _____

Name: _____ Phone #:_____

Street Address/ P.O. Box:_____

Client's Language: English _____ If Other: _____

Baby's Due Date/ DOB: _____ Mother's DOB: _____

Download, complete, and send this form to BFPCReferrals@la.gov

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MAKES BREASTFEEDING WORK