Breastfeeding Peer Counselor Hospital Referral

Today's Date: _____

Staff Name Making the Referral: _____

Would like to Apply for WIC Services: ☐ Yes

Currently Breastfeeding: ☐ Yes ☐ No

Referring Birthing Hospital: _____

Mother's Name: _____ Phone #: _____

Street Address/ P.O. Box: _____

City: _____ Zip Code: _____

Infant's DOB: _____

Language of Client: English

If Other: _____

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

loving support®

MAKES BREASTFEEDING WORK