IBCLC Breastfeeding Plan

Complete and return via email to local agency within 1 week of providing IBCLC services. **Electronic signature accepted.**

Date:

Client Name: **Client Birth Date (m/d/year):**

Phone number: **WIC Family number:**

Reason for referral:

Type of Service:

Phone Call Home Visit Office Visit Telehealth

Length of call Length of home or office visit

Service Status:

Unable to connect Number of times client contact attempted

Reason: Left Message Phone disconnected/wrong number Client unavailable Client declined

Case notes:

- Write notes in space provided below that include describing mom's concern/feeding issues and how addressed.
- Complete this form for each separate date of service provided to the same client. For example, if first provided service via phone and then follow-up with an office visit, complete form twice.

Follow-Up Date:

Scheduled No Follow-Up Issue Resolved Not Needed Client declines

Future service provided will be: Phone Call Home Visit Office Visit

Signature, IBCLC providing service Date