Alaska WIC BF Policies

Sample Referral from a Breastfeeding Peer Counselor and or IBCLC

Name of Client:_____

Address:_____

Phone:_____

Email:_____

Age:_____ Due Date or Baby's DOB:_____

_____ Client needs follow-up help for the following breastfeeding issue:

_____ Client referred to the following services/staff:

- ☐ WIC Staff
- ☐ IBCLC
- ☐ Medicaid/DKC
- ☐ SNAP
- ☐ ATAP
- ☐ TANF
- ☐ Other:_____