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:_____________________________________________