INFANT AND YOUNG CHILD FEEDING CLIENT REFERRAL FORM

Part One: To be completed by community health volunteer

Name of Child/Woman: _____

Date of Birth: _____ Age: _____ Sex: _____

Area: _____

Reason for Referral: _____ Date: _____

Woman	
Pre-test counseling	
Breast conditions	
Infant feeding counseling	
Other	
Describe	

Child	
Growth faltering	
Refusal to eat or drink	
Lethargy	
Illness (e.g., diarrhea, difficulty breathing)	
Other	
Describe	

Referred by: _____ Designation: _____

Referred to (Facility/Service): _____

---------- (CUT HERE) ----------

Part Two: To be completed at health facility

Name of Child/Woman: _____
Referred by: _____ Area: _____
Name of Facility/Department: _____
Problem Identified: _____
Treatment/Service Provided: _____

_____

_____

Recommendations for Follow-up: _____

_____

_____

Provider Name: _____ Signature: _____
Date: _____

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INFANT AND YOUNG CHILD FEEDING REFERRAL REGISTER
(For Use by Community Health Volunteers)

Name: _____ Designation: _____

Area/Zone: _____

Date	Mother's name	Address (zone, house number, landmarks)	Child's name	Child's age (months)	Sex (M/F)	Reason for referral	Referral returned (Yes/No)	Treatment provided at health center	Follow-up recommended	Follow-up given

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