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Lactation Consultation Intake and Consent Form

INTAKE

Date_____

Mother's name_____Partner's name_____Baby's name_____

Mother's DOB_____

Address_____City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ email_____

Taking any medications?_____

Returning to work? Yes/No If yes, when: _____ Occupation? _____

How many pregnancies so far? _____ Pregnancy Loss: How many miscarriages/abortions? _____ How far along?_____

Do you have fertility issues? Yes/No If yes, please describe:
_____

Ever taken hormonal birth control pills? Yes/No If yes, for how long?_____

Did you require help getting pregnant (IVF/Clomid, etc.) Yes/No

Did you experience breast changes during your pregnancy/Pregnancies? Yes/No
Describe:_____

Have you periods always been regular? Yes/No
Describe:_____

Age of first period? ___ Do you commonly experience yeast infections: Yes/No

Have you ever had mastitis? Yes/No Plugged Ducts? Yes/No

Most Recent Birth Experience:

___Vaginal ___VBAC ___Induction___C-Section (Emergency/Routine)

How many weeks gestation: _____ How long did you labor? _____ How long did you push? _____

Did you get an epidural? Yes/No For approximately how long were you receiving IV fluids?_____

Anything you would like to add regarding the birth? Where you satisfied with your baby's birth?_____
_____

Breastfeeding History:

Did you meet with a hospital Lactation Consultant? Yes/No If so, how long after birth? _____

How often did you feed your baby at the breast in the hospital? _____

How long after birth was first breastfeeding attempt made? _____

Did you pump while in the hospital? Yes/No

Did you feed baby via: Breast only/Bottle/Finger-feeding/Other:_____

Did your baby receive any supplemental formula? Yes/No Details: _____

Did you feel your milk "come-in"? Yes/No When your milk came in, did you feel: Full/Engorged/No Change

Do you feel isolated sore or full areas in your breast right now? Yes/No

Do your nipples hurt? Yes/No
Details:_____
_____

Other Children, ages, breastfeeding
duration_____
_____

Were you satisfied with your previous breastfeeding experience(s) (if any)?_____

Baby's Wellness History:

Baby's DOB:_____ Baby's due date_____

Male__ Female__ APGAR scores __/__

Birth weight: ___lbs ___oz Lowest recorded weight:_____ Most recent weight:_____

Location of baby's birth_____Baby's Primary Care Provider_____

NICU stay? why?_____Length of NICU Stay:_____

Was your baby treated medically for Jaundice? Yes/No Low Glucose? Yes/No

How was it treated?_____

Did your baby use a pacifier during your hospital stay? Yes/No Using pacifier currently? Yes/No

Was your baby circumcised before hospital discharge? Yes/No Any reactions, including change in breastfeeding behavior? Yes/No

Did your baby receive the hepatitis B vaccine at birth? Yes/No Any reactions, including change in breastfeeding behavior? Yes/No

Does your baby have special needs? Yes/No Please describe:_____
_____

Baby's Feeding Patterns:

Is your baby only feeding at the breast? Yes/No Approximately how many times per day? _____

If your baby receives bottles, are they of: Pumped breast milk/donated breast milk/Formula? How much supplement per day? (oz. or ml) _____

Average Length of feedings:_____ Who ends feeding? Mom/Baby Longest sleep period? _____hrs.

Output: How many wet diapers on average/day? _____ Stooled diapers/day?_____ Color of poop:_____

Baby's general mood?_____

Is baby on any medications?_____

Any specific concerns regarding your baby?_____
_____

CONSENT

Please initial where consent is given:

_____If necessary, I grant permission for information about this consultation to be sent to my physician/health care providers. Advanced notification will be provided if this is recommended.

_____I grant permission for information from this consultation to be used to further the knowledge of breastfeeding (e.g. in professional groups), with the understanding that no names or identifying features will be used.

_____I understand that a lactation consultation by the International Board Certified Lactation Consultant (IBCLC) may include a visual and manual assessment of the mother's breasts, the baby's mouth and suck, observation of the mother and baby breastfeeding, analysis of information relating to the breastfeeding situation, demonstration of techniques for improving breastfeeding, use of breastfeeding equipment, and recommendation of a treatment plan to resolve breastfeeding issues, which may be adjusted during the course of treatment.

_____I understand that I am responsible for informing the lactation consultant of any relevant information or changes that affect my breastfeeding situation.

_____I have received a Health Insurance Portability and Accountability Act (HIPAA) notice. The Health Insurance Portability and Accountability Act of 1996 is a federal law that sets rules about who can look at and receive your health information. This law gives you rights over your health information and when it can be shared. It also requires your doctors, pharmacists and other health care providers, and your health plan to explain your rights and how your health information can be used or shared.

_____**Payment:** I understand that payment for lactation consultation services is my sole responsibility and expected at the time of service*. Payment is payable by cash, check, or credit/debit card. All reimbursement information/billing codes will be provided to you for insurance company reimbursement if applicable.

*Ariel is an in-network provider for Blue Cross Blue Shield of VT. If this is your insurance carrier, all claim forms will be submitted for you and no payment is required at the time of service.

_____

Name Signature Date