

Mother/Baby Information for Lactation Consultation

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Lactation Consultants

Office/Home Visit Date: _____

Referred by: _____

Mother's information:

Name: _____

Date of birth: _____

Address: _____

Phone: _____

Partner's name: _____

OB/Midwife: _____

Address: _____

Phone: _____

Mother's history:

Medical conditions/illness: _____

Current medications: _____

Do you plan to take oral contraceptives? _____ Y/N

Allergies: _____

Baby's mother: _____

Baby's father: _____

Type of birth: _____

___ Vaginal, w/Epidural? _____ Y/N

Length of labor: _____

___ Cesarean _____ planned / emergency

How many other children do you have? _____

Were they breastfed? _____ Y/N How long? _____

What are your breastfeeding concerns or difficulties? _____

What other information would you like? _____

I understand that a lactation consultation usually includes: (Please initial)

_____ Assessment of mother's breasts.

_____ Assessment of baby related to breastfeedings.

_____ Digital suck exam (not always).

_____ Observing a full breastfeeding.

_____ Use of breastfeeding equipment if needed.

_____ Offering the mother the help and information she needs to establish a satisfying breastfeeding relationship with her baby.

_____ I understand that all medical care is to be provided only by a doctor.

_____ I give my permission for information about this consultation to be sent to the baby's and my medical provider.

_____ When making follow-up telephone calls, you can leave messages:

On voicemail: _____ Y/N Or with: _____

_____ Don't leave messages.

Mother's signature: _____ Date: _____