

Mother/Baby Information for Lactation Consultation

Office / Home Visit Date: _____

Referred by: _____

Mother's information:

Name: _____

Date of birth: _____

Address: _____

City/St/Zip: _____

Phone: _____

Partner's name: _____

Obstetrician / Midwife: _____

Practice name: _____

Fax #: _____

Mother's history:

Medical conditions/illness: _____

Current medications: _____

Plan to use hormonal contraceptives? _____ Y/N

Allergies: _____

Baby's mother: _____

Baby's father: _____

Type of birth: _____

_____ Vaginal, w/Epidural? _____ Y/N

_____ Length of labor: _____

_____ Cesarean _____ planned / unplanned

How many **other** children do you have? _____

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

History of breast or chest surgery or injury? _____

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: _____

Baby's information

Name: _____ (M / F)

Date of Birth: _____

Birth weight: _____ Lowest weight: _____

Where did you birth? _____

Baby's doctor / Pediatrician: _____

Practice name: _____

Fax #: _____

Baby's history:

Gestational age at birth: _____ Age today: _____

Hospital/NICU stay due to illness? _____ Y/N

How long? _____ Reason: _____

Current medications: _____

History of jaundice? _____ Y/N Level: _____

Feedings/24 hours: _____ Length: _____

Supplements? _____ Y/N How often? _____

Diapers/24 hours: _____ Wet: _____ Stools: _____

Use of pacifier? _____ Y/N

Use of pump? _____ Y/N How often: _____

Use of other feeding devices? _____ Y/N

What type? _____

Date of next appointment with baby's doctor: _____