Mother/Baby Information for Lactation Consultation

__ Susan Nelson, IBCLC **__ Kristen Rosin, IBCLC** **__ Deby Wells, IBCLC**

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 #: _____

Baby's information

Name: _____ (M / F)
Date of Birth: _____
Birth weight: _____ Lowest weight: _____

Where did you birth? _____

Baby's doctor: _____
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?

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: _____

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: _____