LACTATION SERVICES CONSENT FORM

- I give my consent for Angie's Lactation Consulting, Home Visits, LLC to work with me and my baby during this consultation for my breastfeeding problem/concern. This consent is for in-person visits, as well as phone conversations, and any information sent/communicated by e-mail, mobile phone, fax, SMS text messages, and/or private social media. I understand that electronic/cellular forms of communication may not be encrypted/secure. Initial consultations include a follow up email and phone call.
- I understand that a lactation consultation may involve:
    - touching my breasts and/or nipples for the purposes of assessment
    - inserting gloved fingers into my baby's mouth to assess suck
    - observation of a breastfeed, and suggestions to enhance latch or position
    - demonstration and use of equipment or supplies that may be recommended
    - demonstration of techniques designed to improve breastfeeding
- I understand a partial or follow-up visit is sometimes necessary. I understand that breastfeeding supplies and/or breast pumps may be recommended as effective management of specific situations.
- I understand that I am responsible for informing the lactation consultant of changes I feel are necessary in the care path at the time of the visit or during the course of follow-up communications. I understand it is my responsibility to call the lactation consultant with progress reports, questions or concerns.
- I give my consent for the lactation consultant to use clinical information and any photographs obtained during our sessions for conferring other health care providers and education of mothers about lactation. I won't be identified in any way, but aspects of my situation may be described and discussed.
- I understand total payment is expected at the conclusion of the consultation. I also understand that Angie's Lactation Consulting, Home Visits, LLC does not give refunds for services rendered.
- I understand that for this lactation consultation and all follow-ups, the lactation consultant will protect the privacy of my personal health information as required by the Code of Ethics of the International Board of Lactation Consultant Examiners, and the Standards of Practice of the International Lactation Consultant Association.
- I have received a copy of this provider's Notice of Privacy Practices.

_____ _____

If Mother agrees (consents), signature here Date

MATERNAL/INFANT INFORMATION

Mother's Name: _____ Mother's Date of Birth: _____ Age: _____ Address:_____ Postal Code:_____ Phone:_____ Cell _____ Email:_____ _____ Preferred method of communication: Call home / Call cell / Email / Text	Baby's Name: _____ Baby's Date of Birth: _____ Birth weight: _____ Gestational age at birth: _____ wks Age today: _____ Birth Location:_____ Date of last pediatric/dr visit: _____ Weight: _____ Date of next scheduled pediatric/dr visit: _____ Baby's other parent's name: _____ Baby's Pediatrician/dr:_____

In your own words, describe the reason for this visit and what you have tried, if anything, to resolve the issue(s) of concern:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

How did you hear about Angie's Lactation Consulting, Home Visits, LLC Services:_____
_____

Family/Maternal Health & Pregnancy/Birth/Postpartum History

Does anyone on either side of the baby's family have any of the following?
○ Allergies to food; list food(s):
_____
Environmental allergies
○Asthma ○Eczema ○Hay Fever ○Breast Cancer
○Diabetes ○Thyroid Disease
○Other_____

Have you ever had, been tested, diagnosed with, or treated for: ○Allergies/Asthma ○ Anemia ○ Heart Disease ○ High Blood Pressure ○ Diabetes ○ Liver Disease ○ Thyroid Disorders ○ GI Disorders ○ Cancer ○ Eating Disorders ○ PCOS ○ Depression ○ Weight Loss Surgery ○ Venereal Disease ○ Sexual Abuse ○ Hemorrhoids ○Pregnancy Loss(es) ○ Abortion(s) ○ Anxiety Disorder ○ Pituitary Disorder
○Other_____

Do you smoke? ○ No ○ Yes; for how long?
_____ ; Packs/day If yes, did you smoke during your pregnancy? ○ Yes ○ No
Was this your first pregnancy? ○ Yes ○ No If no, how many pregnancies? _____
How many children? _____

How long did you breastfeed your other child(ren)?
_____
Difficulties getting pregnant? ○ Yes ○ No
Fertility procedures or medications used:
_____
Difficulties staying pregnant? ○ Yes ○ No
Taking birth control? ○ Yes ○ No Type?
_____
Have you ever had any of the following procedures on your breasts?
○ Breast reduction; year _____ ○ Biopsy; side _____year_____ ○ Implants; year_____ ○ Lumpectomy; side _____ year _____ ○
Nipple problems:_____
○Other surgeries/injuries in the chest area:
_____
Did you have any of the following during this pregnancy?
○ Premature labor ○ Urinary/Other infection ○ Anemia ○ Gestational diabetes ○ High Blood Pressure ○ Fever ○Other_____
If you took any medication, name of med:
_____

Are you taking any of the following?
○ Prenatal/Multi vitamin ○ Antihistamine ○ Diet pills ○ DHA supplement ○ Laxatives ○ Aspirin ○ Antibiotics ○ Cold remedies ○ Diuretics ○ Iron supplements ○ Antidepressants ○ Antacids ○ Pain medication (name/dose//frequency):_____
○ Supplement to increase milk (name/frequency):
_____
○ Other: _____

What type of delivery did you have with this birth? ○ Vaginal (went into labor) ○ Vaginal (following induction)
○ Vacuum/Forceps ○ Unplanned cesarean birth
○ Planned cesarean birth; reason:
_____
○ Induction; reason
_____

Did you have any of the following during this labor and delivery? ○ Premature rupture of membranes ○ Antibiotics ○ Epidural ○ Other drugs for pain ○ Drugs to induce or speed labor (If so, how long was this drug administered?)
_____ Hrs.
○ Total labor longer than 30 hours
○ Pushing stage longer than 2 hours ○ Episiotomy ○ Tear
○ Hemorrhage (if so, how much blood was lost? _____ pints)
○ Other complications of labor and delivery, please describe:
_____
_____

Did you experience any of the following postpartum complications? ○ Urinary/Other infection ○ Low blood pressure ○ High blood pressure ○ Retained placenta ○ Excessive bleeding requiring blood transfusion ○ Other:
_____

Did baby have any of the following during or after birth?
○ Breech presentation ○ Umbilical cord complications ○ Meconium aspiration ○ Breathing difficulties ○ Low blood sugar ○ Jaundice; highest bilirubin level: _____

○ Any other complications?
_____
_____
_____
_____

Feeding History/Management & Infant Behavior

Does your baby have any known health problems? ○ Yes ○ No If yes, please explain:
_____
_____

Is your baby currently on any medication? ○ Yes ○ No If yes, list all medications:
_____
_____

What is your baby's most common state? ○ Sleeping/Sleepy ○ Quite Alert/Calm ○ Fussy ○ Crying

Is your baby's waking on his/her own for feedings? ○ All feedings ○ Most feedings ○ Some feedings ○ Must wake for all feedings

Pacifier use: ○ None ○ Rarely ○ Sometimes ○ Often

Number of diapers in last 24 hrs: Wet: _____ Stools:_____ Color of stools: _____

Where is your baby sleeping at night?
○ His/her own room ○ Crib/Bassinet next to my bed ○ In my bed ○ On top of my chest while I sit in my: ○ bed ○ couch ○ recliner

Did you take a prenatal breastfeeding class? ○ Yes ○ No If yes, where?:_____

Bra size before pregnancy? _____Now?_____

Breast changes since birth: ○ No changes ○ Hard/engorged ○ Heavy ○ Warm ○ Leaking
○ Mature Milk "came in": _____days postpartum

How soon after birth was baby's first feeding?_____hours

Was baby's first feeding at the breast? ○ Yes ○ No

Did a lactation consultant assess breastfeeding before hospital discharge?
○ No ○ Yes; please share what you were told about how your baby was breastfeeding:
_____
_____
_____
_____

Is your baby drinking from bottles? ○ No ○ Breastmilk ○ Formula

If you are pumping, what type of pump you are using? ○ Manual ○ Hospital rental ○ Electric Single/Double; brand: _____
How many times are you pumping every 24 hrs? _____
How much milk are you expressing?_____ ozs./per session

Does one breast produce significantly more milk than the other? ○ Yes, Right ○ Yes, Left ○ No

Has your baby ever had any formula? ○ Yes ○ No If yes, please describe when your baby first received formula and why it was given:
_____
_____
_____

Have you attended a La Leche League or hospital-based breastfeeding moms group meeting? ○ Yes ○ No If you have received help from another lactation consultant or breastfeeding helper, please share any of the information already received; describe what helped and what did not:
_____
_____
_____
_____
_____

What are your breastfeeding goals?
_____
_____
_____
_____

Is there anything else you want me to know?
_____
_____
_____

This information is true and correct to the best of my knowledge.

_____
Signature Date