Camilla Baca
BIRTH SERVICES

CELL: 970.708.4844
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Mother's Name _____

Baby's Name _____

Consultation Date _____

LACTATION INTAKE HISTORY

Problem: ❑ nipple pain ❑ latch ❑ breast refusal ❑ undersupply ❑ oversupply ❑ slow weight gain ❑ multiples ❑ other_____

Others consulted about this breastfeeding issue: ❑ LC ❑ doctor ❑ nurse ❑ LLL ❑ friend ❑ family ❑ doula ❑ other _____

Ultimate breastfeeding goal: ❑ breastfeed exclusively ❑ pump exclusively ❑ bf and pump ❑ bf and supplement ❑ unsure ❑ whatever happens

YOUR HEALTH HISTORY

Any history of: ❑ thyroid ❑ ovarian cyst ❑ Polycystic Ovarian Syndrome (PCOS) ❑ diabetes (type ❑ I ❑ II) ❑ other: _____

Medications currently taking (including herbs and vitamins): _____

Breast or chest surgery or injury: ❑ none ❑ reduction ❑ mastopexy ❑ augmentation ❑ biopsy ❑ injury ❑ other **Date:**_____

Conceive easily: ❑yes ❑ no (how long: _____) ❑ IVF ❑ IUI (donated: ❑ sperm ❑ egg ❑ neither)

Abortion(s): ❑ no ❑ yes (#____ year(s) _____) **Miscarriage(s):** ❑ no ❑ yes (#____year(s) _____)

Miscarriage(s) reason(s): ❑ unknown ❑ _____

Number of other pregnancies: _____ **Number of other children living:** _____

BREASTFEEDING HISTORY

Number of other children breastfed: _____ **How long other child(ren) breastfed: #1:** ____ ❑ wks ❑ mos ❑ yrs

#2: ____ ❑ wks ❑ mos ❑ yrs | **#3:** ____ ❑ wks ❑ mos ❑ yrs | **#4:** ____ ❑ wks ❑ mos ❑ yrs | **#5:** ____ ❑ wks ❑ mos ❑ yrs

How did breastfeeding go with the older child(ren): ❑ easy ❑ difficult (describe): _____

THIS PREGNANCY

Breast changes: ❑ enlargement ❑ tenderness in first trimester ❑ leaking ❑ areola darkening **Any complications:** ❑ no ❑ yes: _____

Bed Rest: ❑ no ❑ yes (start week: _____ until week_____) **Reason:** _____ **Pregnancy length:** _____ wks _____ day(s)

LABOR

How labor began: ❑ spontaneous ❑ induced (how: ❑ pitocin ❑ cervical gel ❑ membrane ruptured ❑ other:_____)

Where: ❑ home ❑ birth ctr ❑ hospital ❑ other **Labor:** ___ hrs **Pushing:** ____ min **Delivery:** ❑ vag (❑ VBAC) ❑ vacuum ❑ forceps ❑ C-sect

Medications during labor: ❑ pitocin ❑ epidural (#cm when started: _____) ❑ narcotic (demerol, nubain) ❑ other _____

Antibiotics: ❑ no ❑ yes (reason: ❑ strep B ❑ fever ❑ C-sect ❑ other _____) **Hemorrhage:** ❑ no ❑ yes (med to stop: _____)

LABOR EXPERIENCE: _____

HOSPITAL / POSTPARTUM

1st nursing: ____ min /hrs after birth ❑ easy ❑ difficult **Sides:** ❑ 1 ❑ 2 ❑ did not occur

1st 24 hours frequency: every_____ hours **2nd 24 hours frequency:** every_____ hours **3rd 24 hours frequency:** every_____ hours

❑ **Circumcision** (Day _____) **Pacifier:** ❑ no ❑ yes (when began: day_____) **Separation:** ❑ none ❑ some ❑ night ❑ mostly nursery ❑ NICU

Milk came in: day ____ ❑ not noticed ❑ slight ❑ mod ❑ heavy **Baby complications:** ❑ jaundice ❑ hypoglycemia ❑ other _____

How treated: _____

INPATIENT BREASTFEEDING EXPERIENCE: _____

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LACTATION INTAKE HISTORY (PAGE TWO)

AT HOME

FEEDINGS: How often: ____ min/hrs **LATCHING:** ❑ easy ❑difficult ❑ impossible **Who ends:** ❑ me ❑ baby **Avg length:** ____ min

Nipple pain: ❑ none ❑ some ❑ moderate ❑ severe **Which nipple(s):** ❑ L ❑ R **When began:** _____ ❑ days ❑ weeks ❑ months

SUPPLEMENTING: ❑ no ❑ yes **When began:** ____ days **How:** ❑ tube ❑ bottle ❑ cup ❑ syringe ❑ dropper ❑ spoon ❑ finger-feeder

When: ❑ before nursing ❑ after **How often:** ❑ every feed ❑ _____ x/day **How much:** ____oz/cc feeding **What:** ❑ pumped milk ❑ formula

HAND EXPRESSING: ❑ no ❑ yes **When began:** ____ day(s) **How often:** _____ times per day **Avg amt:** _____

PUMPING: ❑ no ❑ yes **When began:** ____ days **How often:** _____ times per day **Avg amt:** _____ **Flange size** (imprinted on side): _____

Pump condition: ❑ new ❑ used (how long: _____ mths/yrs) **Pump Type:** ❑ rental ❑ owned (brand: _____)

POST-DISCHARGE BREASTFEEDING EXPERIENCE:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Vaginal bleeding now: ❑ light ❑ moderate ❑ heavy ❑ over **Color:** ❑ bright red ❑ dark red ❑ brown

WHERE BABY SLEEPS: ❑ in our room ❑ in her/his room ❑ other:_____ **What baby sleeps in:** ❑ our bed ❑ sidecar ❑ crib or bassinet

NUMBERS

BABY'S WEIGHT HISTORY

DATE	WHERE WEIGHED	WEIGHT
BIRTH		

DIAPER OUTPUT HISTORY

	Last 24 Hours	Last 25-48 Hours	Last 49-72 Hours	Last 73-96 Hours	Last 97-120 Hours
Stool Quantity					
Stool Amount	❑ More than a spoonful	❑ More than a spoonful	❑ More than a spoonful	❑ More than a spoonful	❑ More than a spoonful
Stool Color	❑ Black ❑ Brown ❑ Green ❑ Yellow	❑ Black ❑ Brown ❑ Green ❑ Yellow	❑ Black ❑ Brown ❑ Green ❑ Yellow	❑ Black ❑ Brown ❑ Green ❑ Yellow	❑ Black ❑ Brown ❑ Green ❑ Yellow

Attend breastfeeding group: ❑ no ❑ yes (Where: _____)

Ideally, want to breastfeed: _____ ❑ months ❑ years ❑ until baby weans self **Returning to work (outside home):** ❑ no ❑ yes (At _____ ❑ weeks ❑ months)

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Acknowledgement and Receipt of Privacy Practices

This lactation consultation practice is required by US federal law to maintain our patients' privacy and provide them with access to the notice of our legal duties and privacy practices with respect to protected health information (PHI). Your signature below hereby acknowledges that you have reviewed our HIPAA Notice of Privacy Practices document and understand that you may obtain a copy for your records upon request.

Printed Name _____

Signature _____

Today's Date _____

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LACTATION CONSULTATION CONSENT FORM

MOTHER

Your Name _____ Your Birth Date ___/___/___ Your Age _____ Your Profession _____

Street Address _____ City _____ State _____ Zip _____

Partner's Name _____ Partner's Profession _____ Best phone to reach you: ☐ Home/Landline ☐ Cell

Phone (home/landline) _____ Phone (cell) Do you text? ☐ Yes ☐ No _____ Email _____

Note that text and email messages are not secure and cannot protect your private health information (PHI)

How would you prefer to receive the report from this consult? ☐ Email ☐ Regular Mail ☐ Faxed To: _____

Referred by: ☐ Friend/Family: _____ ☐ Hospital: _____ ☐ Doctor: _____

Website: ☐ _____ ☐ Internet search ☐ Other referral source: _____

BABY

Baby's Full Name _____ Sex: ☐ M ☐ F Due Date ___/___/___ Birth Date ___/___/___ Weeks Gestation at Birth _____

Place of Birth _____ City/State of Birth _____

HEALTH CARE PROVIDERS

OBSTETRICIAN / MIDWIFE	PEDIATRICIAN
Name _____ Send report? ☐ No ☐ Yes (provide following info):	Name _____
City and State _____	City and State _____
Phone _____	Phone _____
Fax or Email _____	Fax or Email _____

I understand that:

- All medical care is to be provided by my own physician(s) and that any change from his/her/their recommendations should be discussed with him/her/them.
- A lactation consultation by the 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 care plan to resolve breastfeeding issues, which may be adjusted during the course of treatment.
- A student intern may accompany the IBCLC and participate in the consultation for training purposes.
- I am responsible for informing the lactation consultant(s) of any relevant information or changes that affect my breastfeeding situation.
- *It is my responsibility to call the lactation consultant(s) with progress reports, questions, or concerns.*
- Payment for services and supplies are my sole responsibility and required at the time of service; a receipt will be provided for insurance reimbursement.

I grant consent for:

- Information about this consultation to be mailed, faxed, or emailed to my attending physician/health care providers.
- Information from this consultation to be used for teaching purposes, with the understanding that no names or identifying features will be used.
- Treatment according to the scope of practice outlined above.

My signature below acknowledges my understanding of the conditions set forth above.

_____ _____

Client Signature **Date**

_____ INITIALS I give permission for photos and/or videos of my lactation visit to be taken and used solely for educational purposes, including presentations at professional conferences and workshops without further notice or compensation. No identifying information will be present in any photograph or video.