New York Lactation Care Inc.

Rebecca Koyf, IBCLC
International Board Certified Lactation Consultant

CONSENT

- I give my consent for the lactation consultant 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.
- 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 of the use of equipment or supplies that may be recommended, and demonstration of techniques designed to improve breastfeeding.
- 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. Contact during the time following the lactation visit is crucial and considered an extension of your visit. I will be given a phone number to call to report progress or to communicate continued problems or concerns. 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 release any information acquired in the evaluation and/or management of myself and/or my child to our health care providers, referring physician, referring lay breastfeeding counselor, and/or our insurance company upon request. I understand the lactation consultant may contact my physician or my child's physician if the lactation consultant feels it is necessary to consult with the physician.
- I give my consent for the lactation consultant to use clinical information and photographs/video obtained during our sessions for conferring with other health care providers and private client education. 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 will receive an invoice to submit to my insurance company for consideration of reimbursement. I also understand that Rebecca Koyf, IBCLC New York Lactation Care Inc. 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 Health Insurance Portability and Accountability Act of 1996 (HIPPA).
- I have received a copy of this provider's Notice of Privacy Practices.
- I understand that a student lactation consultant may be present to observe my consultation.

____ _______________________________

If client agrees (consents), **signature here** *Date*

CLIENT INFORMATION

Your Name: ________________________

Your Date of Birth: ________________ Age: ________

Address: ________________________

City/State/Zip Code: ________________________

Phone: Home ____________ Cell ____________

Email: ________________________

Mother's OB/Midwife: ________________________

Group Name/Location: ________________________

Phone: ____________ Fax ____________

Baby's Name: ________________________

Baby's Date of Birth: ____________ Birth weight: ____________

Gestational age at birth: ________ wks Age today: ________

Birth hospital/location ________________________

Date of next scheduled pediatric visit: ________________________

Baby's other parent's name: ________________________

Baby's Pediatrician: ________________________

Group Name/Location: ________________________

Phone: ____________ Fax ____________

How did you hear about and/or who referred you to me: ________________________

REASON FOR VISIT

HAVE YOU EXPERIENCED OR ARE YOU CURRENTLY EXPERIENCING/CONCERNED ABOUT ANY OF THE FOLLOWING?

☐ Nipple pain/cracks/injuries ☐ L ☐ R ☐ Internal breast pain ☐ L ☐ R ☐ Painful latch / feedings ☐ Engorgement; ☐ Chronic
☐ Plugged ducts; ☐ Recurring ☐ Mastitis; ☐ Recurring ☐ Milk blister ☐ L ☐ R ☐ Inadequate milk production
☐ Using a nipple shield to nurse ☐ Supplementing, despite intention to exclusively breastfeed ☐ Pumping concerns / difficulty
☐ Postpartum anxiety/depression concerns ☐ Frustration/disappointment/discouragement with breastfeeding

HAS YOUR BABY EXPERIENCED OR IS YOUR BABY EXPERIENCING ANY OF THE FOLLOWING?

☐ Excessive weight loss in first week of life ☐ Inadequate weight gain ☐ Infrequent stools (2 or less a day) ☐Mucousy stools
☐☐Unable to latch ☐ Difficulty latching ☐ Seems to prefer bottle ☐ Does not latch deeply
☐ Latches deeply, then slips down ☐ Clamping/biting on nipple ☐ Spilling milk ☐☐ breast ☐☐ bottle ☐ Clicking while feeding
☐ Sleepy at breast/must be stimulated ☐ Fussing/crying during feedings ☐ Choking/gagging during feedings ☐ Prefers one breast ☐ L ☐ R
☐ Frequent restlessness/seems unsatisfied ☐ Unusually long feedings ☐ Unusually frequent feedings ☐ Congested after feedings
☐ Frequent hiccups /gassiness/spitting up ☐ Rash: Baby acne / Diaper / Body ☐ Persistent white coating on tongue ☐ Cranial molding / bruising
☐ Keeps head turned or prefers looking to one side: ☐ L ☐ R ☐ Noisy breathing/grunting/wheezing during feedings or when at rest

In your own words, describe any other reason for this visit:

____

____

____

YOUR HEALTH / PREGNANCY / BIRTH / POSTPARTUM HISTORY:

HAVE YOU EVER HAD, BEEN TESTED, DIAGNOSED WITH, OR TREATED FOR ANY OF THE FOLLOWING?

☐Anemia ☐ Allergies/Asthma ☐ High Blood Pressure
☐ Diabetes ☐ Thyroid disorders ☐ Depression
☐ Anxiety ☐ Pituitary disorder ☐ Vitamin deficiency
☐ Cancer ☐ Eating Disorders ☐ Venereal disease- ________
☐ Heart Disease ☐ Weight Loss Surgery ☐ Gastrointestinal disorders
☐ Hormonal imbalance ☐ Polycystic Ovary Syndrome
☐Infertility/Assisted conception ☐ Pregnancy Loss(es) # ________

Other: ______________________________

REPRODUCTIVE / BREAST / PRIOR BREASTFEEDING HISTORY / DIET

*Age of first menstruation:*________

Regular cycles in first two years of menstruation? ☐ Yes ☐ No

Anything unusual or of note about puberty/development? ☐ No ☐ Yes; describe: ______________________________

Any concerns during puberty, or since, regarding breast development, size, shape, appearance?

☐ No ☐ Yes; describe: ______________________________

Have you ever had any of the following procedures on your breasts?

☐ Breast reduction; year ________ ☐ Implants; year: ________

☐ Lift; year ________ ☐ Biopsy; ☐ L ☐ R year: ________

☐ Lumpectomy; ☐ L ☐ R year:________ ☐ Nipple piercing: ☐ L ☐ R

☐ Other surgeries/injuries in the nipple/areola/chest area? ________

How many pregnancies have you had? ______*How many live births?*______

If you have other children, were they breastfed?

Child 1 age:______ ☐ Yes; how long?________ ☐ Not breastfed

Describe any breastfeeding difficulties:____________________

Child 2 age:______ ☐ Yes; how long?________ ☐ No breastfed

Describe any breastfeeding difficulties:____________________

Child 3 age:______ ☐ Yes; how long?________ ☐ No breastfed

Describe any breastfeeding difficulties:____________________

If currently using birth control, what type: ____________________

Please check if you are: ☐ Vegetarian ☐ Vegan

Have you restricted your diet due breastfeeding? ☐ **No** ☐ Yes; describe:

____

EXPERIENCE THIS PREGNANCY

If you experienced infertility/assisted conception, please describe medications/procedures used: ____________________

Did you experience breast tenderness and/or breast growth during the first trimester of pregnancy? ☐ Yes ☐ No

Did you have any of the following during this pregnancy? ☐ Anemia ☐ Urinary/Other infection ☐ Gestational diabetes ☐ High Blood Pressure

☐ Other ____________________________ If you took any medication, name of med: ____________________

Type of delivery with this birth? ☐ Vaginal (went into labor) ☐ Vaginal (following induction) ☐ Assisted vaginal (vacuum/forceps) ☐ VBAC ☐ Unplanned cesarean birth ☐ Planned cesarean birth

Reason for induction/cesarean: ____________________

Any of the following during this labor and delivery? ☐Antibiotics ☐ Premature labor/rupture of membranes ☐ Epidural ☐ Spinal ☐ Episiotomy ☐ Tear ☐ Excessive bleeding

Drugs to induce or speed labor: ____________________

☐ Other complication: ____________________

POSPARTUM HISTORY / PLANS

Any of the following postpartum complications? ☐ Retained placenta ☐Urinary/Other infection ☐ Low / High blood pressure ☐ Hemorrhage requiring blood transfusion

Are you still experiencing postpartum bleeding?
☐ No ☐ Yes, light ☐ Yes, moderate ☐ Yes, heavy

Breast changes since birth? ☐ None ☐ Minor changes ☐ Engorgement

☐ Day milk "came in":______ days postpartum

Taking any of the following? ☐ Prenatal/Multi vitamin ☐ DHA supplement ☐ Probiotic ☐ Antibiotics ☐ Stool softener ☐Laxative ☐ Antacid ☐ Iron supplements ☐ Depression / Anxiety meds ☐ Placenta pills

☐ Cold/allergy med: ____________________

☐ Pain med (name/dose//frequency): ____________________

☐ Supplement to increase milk (name/frequency): ____________________

☐ Other: ____________________

If currently on maternity leave, are you returning to work/school?
☐Yes; full time ☐Yes; part time ☐ No ☐ Not sure

Occupation: ____________________

Returning to work/school when baby is ________weeks old

INFANT HEALTH / BEHAVIOR / CARE MANAGEMENT

Did baby have any of the following during or after birth?
☐ Breech presentation ☐ Umbilical cord around neck
☐ Meconium aspiration ☐ Breathing difficulties ☐ Low blood sugar
☐ Jaundice; discharged w bili blanket? ☐ No ☐ Yes; date cleared: _________
☐ Any other complications?____

Does baby have any known health problems? ☐ No ☐ Yes; describe:
____

List any medication/vitamin supplement baby is on: ☐ None
____

Has baby ever gone longer than 24 hrs without stooling?
☐ No ☐ Yes; age?_________________ Days w/out stooling: _________

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

Pacifier use: ☐ None ☐ Rarely ☐ Sometimes ☐Often

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

Between feedings baby is usually: ☐ Swaddled ☐ Held in arms
☐ In a swing/bouncer/rocker/car seat ☐ Worn in a sling/wrap/carrier

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

Do you have help at home with baby care?
☐ Yes, 24/7 ☐ Yes, days only ☐ Yes, evenings only ☐ No

Is your family supportive of you breastfeeding?
☐ Yes ☐ No ☐ They claim to be, but make negative comments; if so, how are you handling this situation?____________________________
____

BABY'S WEIGHT HISTORY:

Date	Baby's age	Where weighed	Weight
Birth	Birth		_____lbs_____ozs
	Discharge		_____lbs_____ozs
	days		_____lbs_____ozs
	days		_____lbs_____ozs
	days		_____lbs_____ozs

FEEDING/PUMPING HISTORY MANAGEMENT

Birth-Day 3: ☐ Exclusively breastfed ☐ Only formula
☐ Breast and expressed colostrum
Reason for supplementation: ____________________________________

Currently: ☐ Exclusively breastfed ☐ Only formula
☐ Breast and ☐ expressed breastmilk ☐ formula
Reason for supplementation: ____________________________________

Is baby waking on his/her own for feedings? ☐ All feedings
☐ Most feedings ☐ Some feedings ☐ Must wake for all feedings *In the past 24 hours, how many times has your baby fed?* ___________ *How many of these feedings were at the breast?*__________

Is baby taking both breasts each breastfeeding? ☐ Yes
☐ No; baby is not interested in 2nd side ☐ No; I'm not offering 2nd side

Is your baby receiving bottles: ☐ Yes, daily ☐ Yes, occasionally ☐ No
Number of bottles in last 24 hrs _______
What brand of bottle are you using: __________________________________

If your baby is receiving bottles, please check why:
☐ Nipple pain/injury ☐ Baby can't latch ☐Baby refuses breast
☐ Was told to supplement by doctor ☐ So helper(s) can feed baby
☐ Baby is restless/seems unsatisfied after breastfeeding
☐ Other: ____

Baby gets bottles: ☐ After breastfeeding; amount given: _________ozs
☐ Instead of breastfeeding; amount given:___________ozs

If your baby is receiving formula, what brand: ______________________
Total ounces of formula a day: _____________ozs

Total given daily by bottle (pumped breastmilk and formula): _______ ozs

Are you pumping: ☐ Yes, daily; number of times/day? ________________
☐Occasionally ☐ Tried it a time or two ☐No

If pumping, what type of pump you are using? ☐ Manual ☐ Rental
☐ Personal use single electric ☐ Personal use double electric
Pump brand/model: ____

Pump source: ☐ New; retail purchase ☐ New; provided by insurance
☐ Used by me with older child ☐ Used by another person prior to me

*How long do you pump each session?*________________min

How much milk are you expressing per session? ______________ozs

What size flanges are you using? ☐ Standard (came with the pump)
☐ Small (purchased separately) ☐ Large (purchased separately)

Does one breast produce significantly more milk? ☐ Yes; ☐ R ☐ L ☐ No

BREASTFEEDING HELP HISTORY & GOALS

What are your breastfeeding goals? ____
____ *If you have received breastfeeding help from another lactation consultant, breastfeeding helper, or healthcare provider, please share who helped you and what suggestions you were given; what helped and what didn't*: ____
____
____
____

Is there anything you've researched/tried on your own to troubleshoot solutions for your breastfeeding concerns? *What helped and what didn't*:
____
____
____

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