



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 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: _____

Baby's Name: _____

Your Date of Birth: _____ Age: _____

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

Address: _____

Gestational age at birth: _____ wks Age today: _____

City/State/Zip Code: _____

Birth hospital/location _____

Phone: Home _____ Cell _____

Date of next scheduled pediatric visit: _____

Email: _____

Baby's other parent's name: _____

Mother's OB/Midwife: _____

Baby's Pediatrician: _____

Group Name/Location: _____

Group Name/Location: _____

Phone: _____ Fax _____

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: _____

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: _____

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: _____

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: _____

POSTPARTUM 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

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: _____

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? _____