LACTATION ASSOCIATES OF ST. AUGUSTINE

Breastfeeding Intake Form Today's date_____

MOTHER Name_____ Date of birth _____
Physician _____
Home address _____
Home phone _____ Cell phone _____ Email_____
Occupation_____ Employer _____Return to work date_____

FATHER/PARTNER (optional) Name _____
Home address (if different than mother)_____
Home phone_____Cell phone _____Email_____

BABY Name _____Date of birth _____Pediatrician_____
BABY Name _____Date of birth _____

How did you find out about our practice? _____
Briefly, what is the reason for your visit today?_____
_____

MOTHER'S HISTORY

List all current medications, birth control, supplements, vitamins or herbs:

Do you use: (circle all that apply)
Prescribed opioids Nicotine/Tobacco Alcohol Recreational drugs

Do you have any of the following? (circle all that apply)
Polycystic Ovarian Syndrome (PCOS) Anemia Heart Disease Thyroid disorder
Eating disorder Infertility issues Diabetes Depression Anxiety BiPolar disorder
Tongue-tie Lip-tie Genetic disorder Cancer Pituitary disorder
Breast or chest surgery

Do you feel unsafe in your home? _____

Number of pregnancies_____ Number of live births_____
Have you breastfed before? _____ For how long?_____

During **this pregnancy,** did you have any of the following: (circle all that apply)
Increase of breast/cup size Gestational diabetes Anemia Infection
High blood pressure Fever Placenta Previa Pre-eclampsia Low amniotic fluid
Severe nausea/vomiting

During **this labor,** did you have any of the following: (circle all that apply)
Pitocin Premature rupture of membranes (PROM) Antibiotics
Epidural other pain medications Hemorrhage Blood transfusion

Describe your breastfeeding goals:

BABY'S HISTORY
Gestational age of baby at birth _____weeks
Birth weight _____lbs ____oz

Delivery: (circle all that apply) Vaginal Forceps Vacuum Extraction
Emergency C-Section Planned C-Section Breech presentation
Umbilical cord complications Meconium aspiration NICU Retained placenta
Jaundice

Baby's health issues:

Baby's medications, vitamins, herbs or supplements:

Baby's feedings

How soon after birth was baby's 1st feeding?_____ At the breast? _____

Check all that apply:

- ❏ Baby is exclusively breastfed
- ❏ Baby needed supplementation early on, but not now
- ❏ Baby gets supplement: Type _____Amount _____Frequency _____
- ❏ Mother uses nipple shield to latch baby: Size ____mm
- ❏ Supplemental Nursing System (SNS)
- ❏ Baby gets a pacifier
- ❏ Baby takes a bottle
- ❏ Baby eats solid food

In the past 24 hours, how many?

_____wet diapers _____stool diapers Color of stool _____

Please describe baby's feeding routine:

Is Mother using a **breastpump**? If yes, what brand of pump? _____
How often?_____ How many minutes? _____Amount milk collected _____oz

Is there anything else you would like your Lactation Consultant to know?

Lactation Associates of St. Augustine

LACTATION SERVICES CONSENT FORM

Please read this form in its entirety, initial your agreement in each box, and sign & date at the bottom.

- ❑ I understand that a Lactation Consultation may include: visual and physical assessment of the mother's breasts, nipples and underarms; visual and physical assessment of the baby's mouth & overall physical condition; observation of a breastfeeding or pumping session; touching of mother's breasts and nipples; demonstration of feeding positions and techniques; demonstration and use of equipment or supplies to improve effectiveness of breastfeeding, measurement of vital signs.
- ❑ I understand that an **IBCLC** (International Board Certified Lactation Consultant) is a specialized health care provider with extensive training in the care of breastfeeding mothers and babies. I understand that all medical concerns must be discussed with a physician.
- ❑ I have read the lactation consultant's HIPAA Privacy Practices posted on the website. I understand I may request a paper copy.
- ❑ I understand a follow-up visit is sometimes necessary and there is an additional fee for this visit.
- ❑ I understand that **payment is due IN FULL at the beginning of the visit**. It is my responsibility to pursue reimbursement for lactation services from my insurance company. Reimbursement is not guaranteed, but filing the claim form with insurance company is strongly suggested. I authorize the Consultant to release any information to my insurance company.
- ❑ I understand that electronic/cellular forms of communication may not be encrypted or secure. I give my permission for *Lactation Associates of St. Augustine* to contact me via:
  ☐Home phone ☐Cell phone ☐Text message ☐Email
- ❑ I understand the Lactation Consultant has the right to terminate a professional relationship with any client at any time and I will not receive a refund.
- ❑ I agree to give 24 hours notice to cancel an appointment.

I have read this consent form and agree to the terms,

Parent 1 _____
Sign and date

Parent 2 _____
Sign and date