History Information for Lactation Consultation

Office / Home / Virtual Visit Date: _____ Referred by: _____

Nursing parent's information:

Name: _____
Date of birth: _____
Address: _____
City/St/Zip: _____
Phone: _____
Partner's name: _____

Obstetrician / Midwife: _____
Practice name: _____
_____
Fax #: _____

Nursing parent's history:

Medical conditions/Illness:
_____
Current medications:
_____
Plan to use hormonal contraceptives? Y/N
Allergies:
Baby's mother: _____
Baby's father: _____
Type of birth:
__ Vaginal, w/Epidural? Y/N
Length of labor: _____
__ Cesarean planned / unplanned
How many ***other*** children do you have? _____
Were they breastfed? Y/N How long? _____
History of breast or chest surgery or injury?
_____

Baby's information (Baby A if twins)

Name: _____ (M / F)
Date of Birth: _____
Birth weight: _____ Lowest weight: _____

Where did you birth? _____

Baby's doctor / Pediatrician: _____
Practice name: _____
_____
Fax #: _____

Baby's history:

Gestational age at birth: _____ Age today: _____
Hospital/NICU stay due to illness? Y/N
How long? _____ Reason: _____
Current medications: _____
History of jaundice? Y/N Level: _____
Feedings/24 hours: _____ Length: _____
Supplements? Y/N How often? _____
Diapers/24 hours: Wet: _____ Stools: _____
Use of pacifier? Y/N
Use of pump? Y/N How often: _____
Use of other feeding devices? Y/N
What type? _____

Date of next appointment with baby's doctor: _____

(If twins, complete Baby B info on page 2.)

What are your feeding concerns or difficulties with this baby?

What other information would you like?

_____

I understand that a lactation consultation usually includes: (Please initial)

_____ Assessment of nursing parent's breasts.
_____ Assessment of baby related to feeding.
_____ Suck assessment.
_____ Observing a full feeding.
_____ Use of feeding equipment if needed.
_____ Offering the parents the help and information needed to establish a satisfying feeding relationship.

_____ I understand that all medical care is to be provided only by a licensed medical practitioner.
_____ I give my permission for information about this consultation to be sent to the baby's and my medical provider.
_____ HIPAA compliant communication method (Spruce) has been offered to me for follow-up communication.

Nursing parent's signature: _____ Date: _____

History Information for Lactation Consultation, page 2

Nursing parent's information:

Name: _____

Date of birth: _____

Baby's information (Baby B if twins)

Name: _____ (M / F)

Date of Birth: _____

Birth weight: _____ Lowest weight: _____

Where did you birth? _____

Baby's doctor / Pediatrician: _____

Practice name: _____

_____

Fax #: _____

Baby's history:

Gestational age at birth: _____ Age today: _____

Hospital/NICU stay due to illness? _____ Y/N _____

How long? _____ Reason: _____

Current medications: _____

History of jaundice? _____ Y/N _____ Level: _____

Feedings/24 hours: _____ Length: _____

Supplements? _____ Y/N _____ How often? _____

Diapers/24 hours: Wet: _____ Stools: _____

Use of pacifier? _____ Y/N _____

Use of pump? _____ Y/N _____ How often: _____

Use of other feeding devices? _____ Y/N _____

What type? _____

Date of next appointment with baby's doctor: _____

What are your feeding concerns or difficulties with this baby?

Nursing parent's signature: _____ Date: _____