Life Stages Feeding
Nutrition Consulting
Infant Support

Brittney Kirton, IBCLC, RHN
www.lifestagesfeeding.com

Lactation intake form Today's date_____

Mother's name:_____ Baby's name:_____

Infant's DOB:_____ Gestation Age: _____Today's age: _____

Birth Weight: _____ Last recorded weight: _____

Mother's OB/Midwife _____ OB/Midwife contact info: _____

Infant's Pediatrician: _____Pediatrician contact info: _____

Referral: _____

Reason for today's visit:

_____

In the last 24 hrs how many times has your baby breastfed?: _____

In the last 24 hrs how many times has your baby voided?:_____Stools?:_____

Is your baby being supplemented with formula? Y / N Expressed breast milk?: Y / N

if yes, reason for supplementation: _____

Are you pumping?: Y / N If yes, how many times in 24hrs?: _____ Average yield:_____

Has your baby been diagnosed with a health condition?: _____

Have you ever breastfed before?: Y / N If yes, how long did you BF for?: _____

Reason for termination?: _____

Number of pregnancies: _____ Number of Children: _____

Was your baby delivered (circle one) vaginally or by cesarean

Any complications?: _____

Have you had any breast injuries /surgeries? Y / N if yes, describe: _____

What do you hope to gain from today's Visit? _____

Is there anything else you would like to share? _____

_____

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Consent Form

A lactation consultation usually includes visual and physical assessment of the mother's breasts, visual and physical assessment of the infant's mouth, observation of the mother and infant nursing, analysis of the data relating to the breastfeeding situation, demonstration of techniques for improving breastfeeding and sometimes the use of breastfeeding equipment. I give permission for the lactation consultant to do all of the above.

I understand that all medical care is to be provided only by our physician(s). I give permission for information about this and all additional consultations to be sent to my attending physician(s)/health care provider(s).

I understand that payment is due at the time of services are rendered. I give permission for information to be released to my insurance company to assist in evaluation of a claim.

I give my permission for information from this consultation/visit to be used to further the knowledge of breastfeeding. I understand that no specific names will be publicly used. I give permission to Brittney Kirton to photograph or videotape myself and/or infant(s). I acknowledge that these images belong to Brittney Kirton and that she intends to use these images for the purpose of education and the promotion of breastfeeding and lactation counselling.

I understand that I have the right to refuse any or all specific techniques suggested, equipment to assist or remedy breastfeeding problems, and/or all recommended actions. Brittney Kirton will provide names of other qualified providers of lactation consultant services or equipment upon request.

_____ _____

Mother's Signature Date

_____ _____

Lactation Consultant's Signature Date