LACTATION CONSULTATION

INTAKE AND CONSENT FORM

Margaret Sabo Wills, IBCLC
(301) 384-8649

MOTHER

Your Name: **Telephone:** **Street Address:**

Your Birth Date: **Age:** **Email:** **City, State, Zip:**

Number of other pregnancies: **Number of other children:** **Number of other children breastfed:**

Partner's Name: **Plans for return to employment/profession:**

How would you prefer to receive the report from this consult: ❑ **email** ❑ **regular mail** ❑ **faxed to**________________________

INFANT

Baby's Name: **Birth Date:** **Sex:** ❑ **M** ❑ **F**

Due Date: **Weeks Gestation:** **Place of Birth:**

WEIGHT HISTORY		
DATE	LOCATION	WEIGHT
Birth /		
Discharge /		
Pediatrician /		

Health Care Providers

OBSTETRICIAN	PEDIATRICIAN
Name:	**Name:**
Address:	**Address:**
Telephone:	**Telephone:**
Fax Number:	**Fax Number:**

Referred by:____ Attend La Leche League or other breastfeeding support group? ❑ Yes ❑ No

Main concern today: ❑ sore nipples ❑ latch difficulties ❑ slow weight gain ❑ other ____

Other professionals consulted about this breastfeeding issue: ❑ LC ❑ Doctor ❑ Nurse ❑ LLL ❑ Friend/Family ❑ Other ____________________

Favorite baby care/parenting expert: ____

I understand that all medical care is to be provided by my own physicians and that any change from a physician's recommendations should be discussed with the physician. I grant permission for information about this consultation to be mailed, faxed, or emailed to my attending physician/health care providers. I grant permission for information from this consultation to be used to further the knowledge of breastfeeding, with the understanding that no names or identifying features will be used. I understand that a lactation consultation by the International Board Certified Lactation Consultant (IBCLC) may include a visual and manual assessment of the mother's breasts, the baby's mouth and suck, observation of the mother and baby breastfeeding, analysis of information relating to the breastfeeding situation, demonstration of techniques for improving breastfeeding, use of breastfeeding equipment, and recommendation of a treatment plan to resolve breastfeeding issues, which may be adjusted during the course of treatment. I hereby give consent for treatment according to the scope of practice outlined above. I understand that I am responsible for informing the lactation consultant of any relevant information or changes that affect my breastfeeding situation**. I understand that it is my responsibility to call the lactation consultant with progress reports, questions, or concerns.** I understand that payment for lactation consultation services and any necessary breastfeeding equipment are my sole responsibility and expected at the time of service. A receipt will be provided for insurance reimbursement.

Mother's Signature **Date** **Margaret Sabo Wills, IBCLC**