LACTATION CONSULTATION

INTAKE AND CONSENT FORM

MOTHER

Your Name _____ Your Birth Date ___/___/___ Your Age _____ Your Profession _____

Street Address _____ City _____ State _____ Zip _____

Partner's Name _____ Partner's Profession _____ Best phone to reach you: ❑ Home/Landline ❑ Cell

Phone (home/landline) _____ Phone (cell) Do you text? ❑ Yes ❑ No _____ Email _____

Note that text and email messages are not secure and cannot protect your private health information (PHI)

How would you prefer to receive the report from this consult? ❑ Email ❑ Regular Mail ❑ Faxed To: _____

Referred by: ❑ Friend/Family:_____ ❑ Hospital:_____ ❑ Doctor: _____

Website: ❑ _____ ❑ Internet search ❑ Other referral source: _____

BABY

Baby's Full Name _____ Sex: ❑ M ❑ F Due Date ___/___/___ Birth Date ___/___/___ Weeks Gestation at Birth _____

Place of Birth _____ City/State of Birth _____

HEALTH CARE PROVIDERS

OBSTETRICIAN / MIDWIFE	PEDIATRICIAN
Name _____ Send report? ❑ No ❑ Yes (provide following info):	Name _____
City and State _____	City and State _____
Phone _____	Phone _____
Fax _____	Fax _____

I understand that:

- All medical care is to be provided by my own physician(s) and that any change from his/her/their recommendations should be discussed with him/her/them.
- A lactation consultation by the 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 care plan to resolve breastfeeding issues, which may be adjusted during the course of treatment.
- A student intern may accompany the IBCLC and participate in the consultation for training purposes.
- I am responsible for informing the lactation consultant(s) of any relevant information or changes that affect my breastfeeding situation.
- *It is my responsibility to call the lactation consultant(s) with progress reports, questions, or concerns.*
- Payment for services and supplies are my sole responsibility and required at the time of service; a receipt will be provided for insurance reimbursement.

I grant consent for:

- Information about this consultation to be mailed, faxed, or emailed to my attending physician/health care providers.
- Information from this consultation to be used for teaching purposes, with the understanding that no names or identifying features will be used.
- Treatment according to the scope of practice outlined above.

My signature below acknowledges my understanding of the conditions set forth above.

_____ _____

Client Signature Date

_____ INITIALS

I give permission for photos and/or videos of my lactation visit to be taken and used solely for educational purposes, including presentations at professional conferences and workshops without further notice or compensation. No identifying information will be present in any photograph or video.

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