



South Carolina Lactation and Newborn Wellness Center Informed Consent

- I give my consent for the South Carolina lactation and newborn Wellness Center (SCLNWC), to work with me and my baby concerning our breastfeeding situation. This consent is for in-person visits, telephone conversations, and includes appropriate follow-up contacts.
- I give consent for SCLNWC, to perform any or all of the following:
 1. Observation of the mother and infant feeding
 2. Analysis of the available data relating to the breastfeeding situation
 3. Demonstrate techniques for improving breastfeeding and, where appropriate, the use of breastfeeding equipment
 4. Visual and physical assessment of the mother's breasts which may involve physically touching the mother's breast
 5. Visual and physical assessment of the infant's mouth, which may involve insertion of fingers in the mouth of the baby.
- I understand that all medical care for myself and my baby is to be provided only by my/our own physician(s). I give permission for information about this and all additional consultations to be shared with and sent to (by electronic or other means) my physician(s) and/or health care provider(s).
- I understand that I have the right to refuse any or all specific techniques suggested, to refuse equipment to assist or remedy breastfeeding problems, and/or to refuse recommended actions.
- I have completed the SCLNWC, medical/feeding history form.

_____ Mother's signature _____ Date

_____ SCLNWC Witness _____ Date

Lactation Consultation – History Form

Mother's Name: _____ DOB _____

Baby's Name: _____ DOB _____

REASON FOR CONSULTATION:

1st Newborn Visit Breast/Nipple pain Poor Nursing Slow weight gain
 Supply problem Other _____

Mother's Health History: Please check any if applicable:

Anxiety/Depression History of Abuse Infertility Diabetes PCOS Breast Surgery
 Postpartum Hemorrhage Thyroid Disorder Pituitary Disorder High Blood Pressure
 Alcohol

Other Medical Conditions/Surgical History: _____



Pregnancy History:

___ Number of Pregnancies ___ Number of live births
Complications during this pregnancy _____
Past breastfeeding experience _____

Birth History:

Labor: Spontaneous ___ Induction ___ Reason: _____
Pain Control: epidural time: ___ Narcotic: ___ Other medications _____
(circle) Vaginal Vacuum Forceps C-Section (reason) _____
Length of labor ___ Length of pushing ___ Time of birth _____
Complications: Mother (labor) ___ Baby (birth) _____

Post Delivery:

How many visits by lactation in hospital ___ Time of 1st breast feed ___
Any bottle feeds in hospital? Yes/No (circle one) Why? _____
Any breast feeding problems in hospital? Yes/No (circle one) If yes, please explain _____

Recommendations from hospital staff _____

Breast Feeding After Discharge from Hospital:

1. When did your milk come in? Day ___ Not in yet ___
2. Are you waking infant for feeds? ___ yes ___ no
3. Longest **average** sleep time for baby? _____
4. Number of breast feeds in last 24 hours? _____
5. How often are you feeding baby? _____ Average length of feeds? _____
6. Feeding at 1 breast or both breasts per feed? _____

Bottle Feeding/Supplementation: (if applicable)

___ Breast Milk ___ Formula
How much? ___ How often? ___ Number of bottles in 24 hours ___
Why supplementing? _____

Pumping:

Do you have a pump? ___ yes ___ no Pump Brand _____ New/Used (circle one)
Are you pumping? ___ yes ___ no Reason? _____ How Long? _____
How many times in 24 hours? _____ Amount pumped? _____ Single/Double Sided (circle one)

Feeding goals:

Environment: (circle one): Calm/Busy Do you have help at home (circle one) yes/no
Who: _____ Returning to work/school (circle one) yes/no (circle one)
Occupation: _____

Any additional information we may need to know?



Sandhills

PEDIATRICS