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