LACTATION CONSULTATION CONSENT FORM

MOTHER

Your Name ______ Your Birth Date ______ Your Age ______ Your Profession ______

Street Address ______ City ______ State/Province/County ______ Postal Code ______

Partner's Name ______ Partner's Profession ______ Best phone to reach you: Home/Landline Mobile

Phone (home/landline) ______ Phone (mobile) ______ Do you SMS/text? Yes No ______ Email ______

SMS/texting and email may contain private health information and may not be secure

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 I ______ Due Date ______ Birth Date ______ Weeks Gestation ______

Place of Birth ______ City of Birth ______

HEALTH CARE PROVIDERS

OBSTETRICIAN / MIDWIFE	BABY'S PHYSICIAN
Name ______ Send report? No Yes (provide following info):	Name ______
Address ______	Address ______
Phone ______	Phone ______
Fax or Email ______	Fax or Email ______

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.
- Payment for lactation consultation services and any necessary breastfeeding equipment are my sole responsibility and required at the time of service; a receipt will be provided.
- *It is my responsibility to call the lactation consultant(s) with progress reports, questions, or concerns.*

I grant consent for:

- Information about this consultation to be mailed, faxed, or emailed to my attending physician/health care providers.
- Information, photographs, and/or video 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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