Kimberly Rush Mothering Support Service

Latch Clinic Client Intake and Consent

MOTHER

Last Name	First Name	MI	Age
Address			
City	State		Zip
Home Phone	Cell Phone		DOB
Occupation	Employer		
EMail			

PARTNER/FATHER

Last Name	First Name	MI	Age
Occupation	Employer		
Cell Phone		DOB	

OB/GYN or MIDWIFE

Last Name	First Name	Group or Practice Name

Referred By

INFANT

Last Name	First Name	MI
Due Date	DOB	Sex: M or F
Present Age (wks.)		
Place of Birth		
Birth Weight	Present Weight	

PEDIATRICIAN or FAMILY PHYSICAN

Last Name	First Name	Group or Practice Name

MOTHER'S HEALTH INSURANCE

Company	ID#

REASONS FOR CONSULTATION

☐ Sore nipples/breasts ☐ Help with latch on and positioning ☐ Tongue or lip tie ☐ Sleepy baby ☐ Fussy baby

☐ Engorgement ☐ Flat or inverted nipple(s) ☐ Preterm infant ☐ Rubber nipple preference ☐ Pumping advice

☐ Other: ____

Please circle any that applies to you:

Have you ever had infertility, polycystic ovarian syndrome, thyroid disease, diabetes, Reynaud's, or breast surgery?

Changes in your breasts during pregnancy: increase in size/tenderness/visible veins/stretch marks/darkening of the areola and nipple?

Type of delivery: vaginal or cesarean section Number of children ___________

In the past 24 hours, how many times has your baby been fed at the breast? _________ Average length of feeding ______ minutes

Breastfeeding/pumps *how often*___________ *how long* _____________mins/side *Pump type* ___________ yields _________ml/oz

Supplemental feeding ☐ No ☐ Yes ______________ml/oz Type of Supplement: __ breastmilk ___ Formula

Number of Diapers in past 24 hrs.: _______ Wet ________ Stool

Do you have pain with feedings? ☐ Yes ☐ No

Currently, is your pain worse on one side than the other ☐ Worse on left ☐ Worse on right ☐ Same on both sides

When is the pain most intense? ☐ Beginning of feed ☐ During feeding ☐ After feeding ☐ With pumping ☐ All the time

How would you describe your pain? ____

*If you are taking any treatments for pain, please list*____

Have the treatments been helpful? ☐ Yes ☐ No ☐ Some

Are you currently taking any medications? Please list ____

Other information you think is helpful ____

Consent Agreement to be READ, INITIALED & SIGNED before the Lactation Consultation

_________ I understand the following: The lactation consultant is an allied health care provider and responsible for evaluating and recommending a care path to resolve or improve breastfeeding issues. A lactation visit includes a history of mother/infant, and may involve the following assessment and/or treatment services, including but not limited to: touching my breasts and/or nipples for the purposes of assessment; inserting gloved fingers into my baby's mouth to assess suck and oral cavity; observation of a feeding for evaluation of technique and effectiveness of feeding, and suggestions to enhance latch or position; demonstration of the use of equipment or supplies that may be recommended, and demonstration of techniques designed to improve breastfeeding. The client and the lactation consultant each have responsibilities in this path. Resolution of a breastfeeding problem often takes several days or weeks and may require a change in the original recommended care path at some point. I grant my permission for lactaion consultation services.

_________ I understand that the latch clinic is a shared visit with other women and their babies and therefore will not be completely private. Each client's participation is strictly voluntary. Because group visits involve clients disclosing private medical and social information, all participants in a group visit must agree to respect the privacy of all participants and keep their information confidential. By signing this confidentiality agreement, I assume the responsibility for keeping all information confidential.

_________ I understand that I am responsible for informing the lactation consultant of changes I feel are necessary in the care path at the time of the visit or during the course of follow-up communications. **I understand it is my responsibility to call the lactation consultant with progress reports, questions or concerns.**

_________ I understand any change from my physician's recommendations should be discussed with the physician. Health care issues of a medical nature MUST be discussed with a physician.

_________ I understand a partial or follow-up visit is sometimes necessary. The Latch Clinic is not meant to be a full in-depth consultation and we are not able to fully address complicated issues in this setting. In depth problem solving may require a second visit to latch clinic or a full consultation. I understand that breastfeeding supplies and/or breast pumps may be recommended as effective management of specific situations. Only effective equipment will be recommended.

_________ I hereby authorize the lactation consultant to release any information acquired in the evaluation and/or management of myself and/or my child to our health care providers, referring physician, and/or our insurance company upon request. I understand the lactation consultant may contact my physician or my child's physician if the lactation consultant feels it is necessary to consult with the physician. I give my consent for the lactation consultant to use clinical information obtained during our sessions for education of other health care providers and other mothers/clients about lactation. I understand that my baby and I will not be identified in any way, but that details and / or other aspects of our situation might be described and discussed.

_________ I understand this practice accepts only **fee for service at time of service.**

_________ I give permission for photographs and audio and/or visual recordings to be made, of both my baby and me, for charting and clinical/education purposes, as well as advertising or marketing of the lactation consultant. These materials might include printed or electronic publications, Web sites or other electronic communications. I authorize the use of these images without compensation to me. All prints and digital reproductions shall be the property of Kimberly Rush.

_________ I agree to have communications about my case be sent by email/text. I understand that this is not a secure or encrypted means of communication, and the materials may contain protected health information (PHI).

_________ I understand that for this lactation consultation and all follow-ups, Kimberly Rush, RN, BSN, IBCLC, will protect the privacy of my personal health information as required by the Code of Professional Conduct of the International Board of Lactation Consultant Examiners (IBLCE), the IBLCE Scope of Practice for IBCLCs, the Standards of Practice of the International Lactation Consultant Association, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I have received a copy of this provider's Privacy Practices which is located on the practice website.

Mother's Signature____ Date_____________________

Lactation Consultant's Signature _____________________________________ Date ______________________