LACTATION CONSULTATION CONSENT FORM

PARENT

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: _____

BABIES

Baby #1's Full Name _____ Sex: ○ M ◉ F

Baby #2's Full Name _____ Sex: ○ M ◉ F

Baby #3's Full Name _____ Sex: ○ M ◉ F

Baby #4's Full Name _____ Sex: ○ M ◉ F

Place of Birth _____ City of Birth _____ Due Date _____ Birth Date _____ Weeks Gestation _____

HEALTH CARE PROVIDERS

OBSTETRICIAN / MIDWIFE

Name _____ Send report? ○ No ○ Yes (provide following info):

Address _____

Phone _____

Fax or Email _____

BABIES' PHYSICIAN

Name _____

Address _____

Phone _____

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 my breasts, the babies' mouth and suck, observation of e 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 for insurance reimbursement.
- *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.