LEILANI'S WELLNESS CENTER AND BREASTFEEDING FIXERS

Leilani Songer IBCLC

2667 Camino Del Rio South Suite 201 SD CA 92108

Consent for Clinical Photography and/or Video Testimonial

I, _____, hereby give my permission for Leilani's Wellness Center and Breastfeeding Fixers for telemedicine or to take clinical photos/videos of myself and/or my baby or child

_____, for the purposes of medical record documentation and to be used to educate doctors, nurses, medical students and Lactation Specialists about the problems associated with breastfeeding. I understand that these photos/videos may be used without patient identification as part of formal lectures to the above individuals and may be included without identification in the medical literature as part of an article to educate professionals to support breastfeeding families. If a video testimonial was provided, I authorize this to be used by Leilani's Wellness Center and Breastfeeding Fixers to promote their practice to the public.

_____ _____

Signature of Patient or Mother / Date Witness Signature / Date

_____ _____

Signature of Patient or father / Date Witness Signature / Date

Leilani's Wellness Center and Breastfeeding Fixers
2667 Camino Del Rio South SD CA 92108
Leilani Songer IBCLC, ICP Micro Current Neurofeedback Practioner

HIPAA RELEASE FORM – Child and/or Parent I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

You have informed me of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent.

I understand that this organization has the right to change its Notice of Privacy Practices from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name:
_____

Parent's Name:
_____

Parent's Signature: _____

Relationship to Patient:
_____

Date: _____

Leilani's Wellness Center and Breastfeeding Fixers
Leilani Songer, IBCLC
2667 Camino Del Rio South • Suite 201 • San Diego, CA 92208-3733 v2-28-20

Pre-release Infant Assessment

Date:_____ Baby's Age:_____ POD: **ZERO**
Baby last fed at: _____ (circle: snack or meal?)
Baby's Name_____ Mom's Name_____
Lactation Consultant's Name _____ Last seen: _____
CranioSacral Therapy Provider: _____Last seen: _____
Present: Mom Dad Sister Brother PGF PGM MGM MGF M-Aunt P-Aunt Nanny Other:

1. How is breastfeeding (on the bare breast) over all?
   Right side: It's effortless now Good OK Fair Not Good Not Nursing
   Left Side: It's effortless now Good OK Fair Not Good Not Nursing
   A typical nursing lasts _____ min then he/she waits **and/or** sleeps for _____ hr.

   Are you: (**circle all** that apply) a. breastfeeding **only** b. feedings **start** with nursing
   c. using a nipple shield **(circle):** all nursings / some nursings / not using one
   d. Giving breastmilk / donor milk / formula using: feeding tube bottle finger

   (If not nursing, go to #8)
2. **Bare Breast Latch** takes <15 sec: **Right side:** yes no NA **Left side:** yes no NA
3. What % of feedings are comfortable on the right? 100% 75% 50% 25% None

   What % of feedings are comfortable on the left? 100% 75% 50% 25% None
4. Latch pain is (0-10) **at first** on right: _____ on left: _____ **then goes to** (0-10)
   on right: _____ on left: _____ and this happens over about _____ minutes
5. Are your nipples misshapen (not round) after nursing? No Yes
   If yes: on right on left both Is it painful? No **If yes:** right left both
6. Is there any blanching (white or purple color) of the nipples after nursing? No Yes
   If yes: on right on left both Is it painful? No **If yes:** right left both
7. Do you clearly hear sustained gulps during a letdown (rapid milk flow)? Yes no
   Do you clearly hear sustained gulps between letdowns (slower flow)? Yes no
8. I am pumping after: every nursing/some nursings (pumping _____x/day)/not at all
   I usually get _____ oz from the right and _____ oz from the left breast.
9. In the last 24 hours: # of good wet diapers _____, # of good poos _____

Anything else to tell us?

Breastfeeding Fixers and Leilani's Wellness Center
Leilani Songer, IBCLC
2667 Camino Del Rio South • Suite 201 • San Diego, CA 92108 v03/16/20

Post-release Infant Assessment

Date: Infant's Age: POD:
Baby last fed at: _____ (circle: snack or meal?)
Infant's Name: Mom's Name:
Lactation Consultant's Name _____ Last seen:
Chiro/CranioSacral Therapy Provider: _____Last seen:
_____
Present: Mom Dad Sister Brother PGF PGM MGM MGF M-Aunt P-Aunt Nanny Other:

1. How is breastfeeding (on the bare breast) over all?
   Right side: It's effortless now Good OK Fair Not Good Not Nursing
   Left Side: It's effortless now Good OK Fair Not Good Not Nursing
   A typical nursing lasts _____ min then he/she waits **and/or** sleeps for _____ hr.

   Are you: (**circle all** that apply) a. breastfeeding **only** b. feedings **start** with nursing
   c. using a nipple shield **(circle):** all nursings / some nursings / not using one
   d. Using a: feeding tube bottle finger to give breastmilk / donor milk / formula

   (If not nursing, go to #8)
2. **Bare Breast Latch** takes <15 sec: **Right side:** yes no NA **Left side:** yes no NA
3. What % of feedings are comfortable on the right? 100% 75% 50% 25% None

   What % of feedings are comfortable on the left? 100% 75% 50% 25% None
4. Latch pain is (0-10) **at first** on right: _____ on left: _____ **then goes to** (0-10) on right: _____ on left: _____ and this happens over about _____ minutes
5. Are your nipples misshapen (not round) after nursing? No Yes
   If yes: on right on left both Is it painful? No **If yes:** right left both
6. Is there any blanching (white or purple color) of the nipples after nursing? No Yes
   If yes: on right on left both Is it painful? No **If yes:** right left both
7. Do you clearly hear sustained gulps during a letdown (rapid milk flow)? Yes no
   Do you clearly hear sustained gulps between letdowns (slower flow)? Yes no
8. I am pumping after: every nursing/some nursings (pumping _____x/day)/not at all
9. In the last 24 hours: # of good wet diapers _____, # of good poos

Anything else to tell us?

Breastfeeding Fixers And Leilani's Wellness Center
Leilani Songer IBCLC
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Date of Visit:_____

Infant's Name (First Middle Last):_____

DOB_____ Gestational age at birth: _____weeks _____days; Sex: Male Female

Birth Weight:_____ 24 hour weight:_____ Lowest weight:_____

Breech? Y N Complications?: No Yes:_____

Birth Medical Center is: _____

OB/Midwife (First, Last): _____

Mother's Name (First Last):_____ DOB_____

Mother's Cell Phone #:_____ Email:_____

Family's Address: _____

City_____ State _____ Zip _____

Father's Name (First Last):_____

Father's Cell Phone#:_____ Email: _____

Family Pediatrician (First, Last): _____ Office Phone:_____

Office Address: _____Last seen: _____

Lactation Consultant (First, Last) :_____ Office Phone: _____

Office Address: _____Last seen: _____

Family Craniosacral Therapist**:**_____ Office Phone:_____

Office Address: _____Last seen: _____

Who referred you to our practice?**:** _____

Ethnicity: a. Hispanic/Latino b. Asian c. Pacific Islander d. Other**:**_____

Preferred Language: a. English b. Other**:** _____ Race**:** _____

About Your Pregnancies

Did you need medical intervention to get pregnant? No **If yes, what?** _____

Was this your first pregnancy? Yes No **If No**, How many pregnancies? _____

How many children do you now have? _____ Did you breastfeed your other child(ren)?: Yes No N/A

If yes, what was you longest previous breastfeeding experience?:_____

If yes, were there nursing problems?: No Yes**:** _____

Which family planning methods are you planning on using? Norplant Depo shot Barriers
Mini pill Vasectomy Tubes tied Natural family planning/rhythm IUD None

Did mom have breast/nipple changes during pregnancy? Yes No
If not, have they enlarged since delivery? Yes No

Was the delivery: Vaginal C-Section Vacuum Forceps Pitocin induced/augmented Epidural Fentanyl
Un-medicated Natural Birth

Have you had any breast surgery? No If Yes: Nipple Piercing: Right Left Both
Breast implants Breast reduction Year done_____
Where was the incision?:
Cup size before surgery _____ Cup size after surgery_____

Have you had any of the following conditions related to your breast? Lumps Biopsy

Fibrocystic disease Other breast disorder: _____ None

During this pregnancy have you had: Premature labor Gestational diabetes Depression

High blood pressure Anemia Fever Urinary tract infection Placenta Previa Preeclampsia

Did the baby have any of the following after birth: NICU - Days_____Hrs._____

Breathing difficulties Low blood sugar Meconium aspiration Deep suctioning

Irregular heart rate Jaundice: Highest bilirubin_____

Is mom on any medications or vitamins? No If yes, what? _____

Do you take any Herbs for your milk production? No Yes, I take: Fenugreek Goat's Rue

More Milk Plus Malunggay Mother's Milk Tea Other_____

Is baby on any medications or vitamins? No If yes, what?_____

Breastfeeding this infant

Are you exclusively breastfeeding? Yes No: We are nursing at the breast AND

supplementing with: Pumped Breastmilk Shared/Donor Breastmilk Formula

If supplementing: Is this given with every feeding **OR** given about #_____feedings each day.

How is this being given?: Plastic tube at the breast Finger feeding Syringe only

Cup Spoon Regular Flow Bottle Slow Flow Bottle

Do you need a nipple shield to nurse? Yes No, but I have used one No, never used one

With this baby, have you had:

Nipple cracks? No Yes: Right - Left – Both Is this still present?: Yes No

Nipple bleeding? No Yes: Right - Left – Both Is this still present?: Yes No

Open sores/missing pieces? No Yes: Right - Left – Both Is this still present?: Yes No

Nipple Scabs? No Yes: Right - Left – Both Is this still present?: Yes No

Are your nipples now red or swollen after nursing? No Yes: Right - Left – Both

Are your nipples now flattened or creased after nursing? No Yes: Right - Left – Both

Are your nipples now white or purple after nursing? No Yes: Right - Left – Both Painful? Y N

How long does it take to latch your baby to the breast WITHOUT using a nipple shield?

Right: _____ Left _____

And <u>WITH</u> a nipple shield? Right:_____ Left_____ **N/A - Do not use one**

Using a Pain Scale of 1 to 10 (5 = teeth gritting, 7 = toe curling, 10 = sawing off your leg):

The initial latch pain is level Right: _____ Left: _____ which finally improves **or** worsens to level Right: _____ Left: _____ over a period of _____ seconds or minutes (circle)

With a nipple shield the initial latch pain is Right: _____ Left: _____ and improves to levels Right: _____ and Left: _____ OR: NA – Do not use a nipple shield

How long is a typical breastfeeding? _____ Typically nurses: 1 side only both breasts

How long does your baby sleep between feedings? Day _____Night_____

Does your baby go on and off the breast a lot during a nursing? No Sometimes Often

Does your baby's upper lip curl in while nursing? No Sometimes Often

If the upper lip curls in, when you pull it out, does it stay out? No Sometimes Usually N/A

What nursing position have you been using? Cradle Cross-cradle Football Side Lying

Are you pumping? No Yes, I am using: A Manual Pump / A Single Electric Pump / A Pump from Insurance

A Double Electric Pump which is: _____ a Home Use Pump or: _____ a Hospital Grade Rental Pump

How often do you pump? _____ since my baby was _____ days / weeks old

Each time I pump I get about the following number of ounces:

Before nursing: Right _____ Left_____ **After nursing:** Right _____ Left _____

For this Baby

In the last 24 hours my baby has had about # _____ really wet diapers

In the last 24 hours my baby has had about #_____ poops that were bigger than a half dollar.

The color of the last poop: Black Dark Green Yellow-Green Mustard

Has anyone found a Tongue Tie or Upper Lip Tie in your baby? No If Yes, who found it?:

LC in Hospital Private Practice LC Hospital MD Office Practice MD Other: _____

Is there a family history of Tongue Tie on either side of the family? No If Yes, who? _____

Have you seen your baby extend the tip of the tongue out ½ inch past the lower lip? Yes No

Does baby snore or grunt while lying on his/her back? Yes No

Does milk leak out from your infant's mouth while nursing? Yes No

While bottle-feeding? Yes No NA – No Bottle

When your baby rests his/her head, is it ALWAYS to the: _____ right _____ left or _____ no preference.

Is there a Family History (either side) of a Bleeding Disorder of any kind?

No Don't know Yes, Who?: _____ What disorder?:_____

Is there anything else you would like us to know about your breastfeeding experience with this infant?
If so, please comment here:

AUTHORIZATION AND ASSIGNMENT OF BENEFITS TO MEDICAL PROVIDER

Patient's Name_____
Insured's Name_____
Benefits/Social Security
No._____
Policy No. _____
Insurance Company_____
Address_____
City_____State_____Zip_____

Medical Provider:

Breastfeeding Fixers and
Leilani's Wellness Center
2667 Camino Del Rio South
Ste 201, SD CA 92108

I authorize the RELEASE OF ANY INFORMATION concerning my health to any insurance company, attorney or adjuster as necessary to process any claim for payment to the above-named medical provider's charges incurred by me.

I permit a COPY OF THIS AUTHORIZATION to be used in place of the original.

NOTICE TO INSURANCE COMPANY OF ASSIGNMENT
You are instructed to PAY DIRECTLY TO THE above-named medical provider at his/her office for all professional services rendered to me by his/her office. This instruction to you is an assignment of my rights under the medical coverage of the insurance policy or my rights under the third-party liability claim. Any Sum of money paid under this assignment shall be credited to my account.

Patient Signature:_____

Insured's Signature:_____
(if different or required)