Client Information and Consent Form

MOTHER'S INFORMATION

Mother's Name		Date of Birth
Home Address		
Mailing Address		
Phone #	Mobile #	Alternate Phone #
Email		
Occupation		
Mother Primary Health Care Provider(s)		
Provider's Phone #		Fax #
Partner's Name		Date of Birth
Partner's Occupation		
Emergency Contact Name		Emergency Contact Phone #
Who referred you to this practice		

INFANT'S INFORMATION

Infant's Name		Date of Birth
Birth Place	Birth Weight	Sex: F ☐ M ☐
Infant's Health Care Provider(s)		
Infant's Provider's Phone #		Fax #

INSURANCE INFORMATION

Mother's Insurance Carrier	Member ID	Group ID
Infant's Insurance Carrier	Member ID	Group ID

OTHER DETAILS

Kara Rambo, IBCLC
Registered Board Certified Lactation Consultant

Tel: (734) 546-3112
kara@caringlactation.com

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MOTHER'S INFORMATION

Mother's Name | Date of Birth

Home Address

Mailing Address

Phone # | Mobile # | Alternate Phone #

Email

Occupation

Mother Primary Health Care Provider(s)

Provider's Phone # | Fax #

Partner's Name | Date of Birth

Partner's Occupation

Emergency Contact Name | Emergency Contact Phone #

Who referred you to this practice

INFANT'S INFORMATION

Infant's Name | Date of Birth

Birth Place | Birth Weight | Sex: F ☐ M ☐

Infant's Health Care Provider(s)

Infant's Provider's Phone # | Fax #

IF MULTIPLES, ADDITIONAL INFANTS HERE

Infant's Name | Date of Birth

Birth Place | Birth Weight | Sex: F ☐ M ☐

Infant's Name | Date of Birth

Birth Place | Birth Weight | Sex: F ☐ M ☐

Infant's Name | Date of Birth

Birth Place | Birth Weight | Sex: F ☐ M ☐

INSURANCE INFORMATION

Mother's Insurance Carrier | Member ID | Group ID

Infant's Insurance Carrier | Member ID | Group ID

Lactation Consultation Intake Form

Today's Date	
Mother's Name	Date of Birth
Infant's Name	Date of Birth

In your own words describe any feeding problems that concern you:

HEALTH HISTORY

Does anyone on either side of the infant's family have any of the following?

- ☐ Food Allergies
- ☐ Environmental Allergies
- ☐ Asthma
- ☐ Eczema
- ☐ Hay Fever
- ☐ Breast Cancer
- ☐ Diabetes
- ☐ Genetic Disease
- ☐ Thyroid Disease
- ☐ Alcoholism
- ☐ Tongue Tie
- ☐ Other: _____

Do you presently have or have you ever had any of the following?

- ☐ Anemia
- ☐ Allergy/Asthma
- ☐ Diarrhea (chronic)
- ☐ Cancer
- ☐ Fertility Issues
- ☐ Kidney/Bladder Disease or Infection
- ☐ Heart disease
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Abortions
- ☐ Depression
- ☐ Yeast Infections
- ☐ Other: _____
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Liver Disease
- ☐ Sexual Abuse
- ☐ Abnormal Pap Smear
- ☐ Tuberculosis
- ☐ Thyroid Disorders
- ☐ Miscarriages
- ☐ Hemorrhoids
- ☐ Constipation
- ☐ Eating Disorder
- ☐ Polycystic Ovarian Syndrome

Are you taking any of the following? (Circle)

- ☐ Prenatal Vitamins
- ☐ Iron
- ☐ Antihistamines
- ☐ Pain Pills
- ☐ Aspirin
- ☐ Cold Remedies
- ☐ Antibiotics
- ☐ Laxatives
- ☐ Diuretics
- ☐ Fish Oil
- ☐ Stool Softener
- ☐ Probiotics

Herbs (List): _____ Other RX/Supplements: _____

Special Dietary Consideration: _____

Do you smoke? Yes ☐ No ☐ Do you consume alcohol? Yes ☐ No ☐ Frequency: _____

Have you ever had any of the following procedures/issues on your breasts?

- ☐ Biopsy
- ☐ Lumps
- ☐ Chest Tube
- ☐ Breast Reduction
- ☐ Nipple Problems
- ☐ Other: _____

PREGNANCY AND BIRTH HISTORY

Conception was:

- ☐ Uncomplicated
- ☐ Took more than 6 months
- ☐ Via IVF/IUI
- ☐ Adoption
- ☐ Surrogate Used
- ☐ Other: _____

What age were you when you had your first menstrual period? _____

Are your periods regular or irregular? Regular ☐ Irregular ☐

Number of Pregnancies: _____ Number of Live Births: _____ Number of Loses: _____

Other Children Name(s) and Date(s) of Birth: _____

Previous breastfeeding issues? If yes, explain: _____

Which of the following family planning methods are you using or do you plan to use? (Circle)

☐ Norplant ☐ Birth Control Pills ☐ Tubes Tied ☐ Natural Family Planning/Rhythm
☐ Injection (Depo) ☐ Vasectomy ☐ NuvaRing ☐ Other: _____
☐ Barriers ☐ IUD (copper or Mirena) ☐ None

Will you be returning to work? Yes ☐ No ☐ Full Time ☐ Part Time ☐ When? _____

Did you have any of the following during this pregnancy?

☐ Preterm Labor ☐ Infection/Fever ☐ Gestational Diabetes ☐ High Blood Pressure
☐ Nausea/Vomiting ☐ Severe Anemia ☐ Other: _____

Did you have any of the following during this labor and delivery?

☐ Premature/Artificial Rupture of Membranes ☐ Pain Meds ☐ High Blood Pressure ☐ Epidural ☐ Fever
☐ Antibiotics ☐ GBS+ ☐ Pitocin/Induction Meds ☐ Episiotomy/Tear ☐ Hemorrhage/Excessive Bleeding

What type of delivery did you have with this birth?

☐ Uncomplicated Vaginal Delivery ☐ Planned Cesarean ☐ Other: _____
☐ Complicated Vaginal Delivery ☐ Emergency Cesarean

Gestational age of infant at birth? _____ weeks _____ days Location of Delivery: _____

POSTPARTUM HISTORY

Did you experience any postpartum complications?

☐ Infection (Type) _____ ☐ Low/High Blood Pressure ☐ Excessive Bleeding/Hemorrhaging
☐ Retained Placenta ☐ Other: _____

After birth did the infant have any of the following?

☐ Breathing Difficulties ☐ Meconium Aspiration ☐ High Hematocrit ☐ Low Blood Sugar
☐ Jaundice (Highest Bili Level) _____ ☐ Other: _____

Does your infant have health problems? If yes, explain: _____

Is the infant currently on any medications? If yes, list: _____

BREASTFEEDING HISTORY

When did your breastfeeding difficulties begin? _____

Did you experience breast changes in pregnancy? Yes ☐ No ☐

Have you experienced any of the following breast changes since birth?

☐ Hard/Engorged ☐ Heavy ☐ Warm ☐ No Changes ☐ Leaking

What were the first several days of breastfeeding like? _____

What does your feeding routing look like now? _____

_____

Have you used any breastfeeding supplies or pumps? Yes ☐ No ☐ Type of Pump _____

Frequency of Pumping? _____ Yield When Pumping (oz/mls per session) _____ Flange size? _____

Has your baby been supplemented with any of the following?

☐ Water/Glucose Water ☐ Expressed Breastmilk ☐ Other: _____
☐ Donor Milk ☐ Formula _____

If so, how was the baby supplemented?

☐ Feeding Tube ☐ Finger Feeding ☐ Other: _____ Pacifier ☐ Yes
☐ Bottle Type: _____ ☐ Cup Feeding ☐ No

If supplementing, how often in the past 24 hours? _____ **How much per feeding?** _____

How many times in the past 24 hours have you breastfed your baby?

☐ Less than 6 times ☐ Less than 8 times ☐ 8-10 times ☐ More than 12 times

Please mark all that apply:

☐ Using a Nipple Shield
☐ Latch-on Difficulties
☐ Engorgement
☐ Breast Pain
☐ Sore Nipples
☐ Sleepy Baby
☐ Cracked/Bleeding Nipples
☐ Baby Not Interested
☐ Baby's suckling less than 5 min/sleepy at breast
☐ Baby Always Seems Hungry Baby Crying Excessively
☐ Preference for one Breast
☐ Feeling There is Not Enough Milk
☐ Other: _____

Is the baby content between feedings?

☐ Never ☐ Occasionally ☐ Often ☐ Comments: _____

What is the average time between feedings?

☐ Day: _____ hrs ☐ Night: _____ hrs

How long does a nursing session last? _____

Baby takes: ☐ One Breast ☐ Both Breasts

Who decides when the feeding is over? ☐ Mother ☐ Baby

How many months do you wish to breastfeed your baby?

☐ 1 month
☐ 2-3 months
☐ 3-6 months
☐ 6-9 months
☐ 12 months
☐ Longer than 12 months
☐ Other: _____

OTHER INFORMATION

In the past 24 hours, how many:

Wet Diapers: _____ Stools: _____ Stool Colors: _____

Is your baby...?

☐ Gassy ☐ Spitting Up ☐ Hiccuping ☐ Other: _____

How would you describe your general mood? (select all that apply)

☐ Happy
☐ Sad
☐ Depressed
☐ Exhausted
☐ Anxious
☐ Nervous
☐ Stressed
☐ Overwhelmed
☐ Foggy
☐ Detached
☐ Worried
☐ Scared
☐ Ecstatic
☐ Fragile
☐ Up-and-down
☐ Other: _____

Is your partner supportive? Yes ☐ No ☐

Anything else you want the lactation consultant to know?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Lactation Consultant Liability Waiver

Please read each of the statements and sign below:

I understand that Caring Lactation, LLC is not liable for my health or safety. In consideration of my participation in the Services, I, _____ hereby accept all risks to my health, including injury or death that may result from such participation, and I hereby release Caring Lactation, LLC and Kara Rambo, IBCLC from any and all costs, claims, causes of action and damages arising from any and all illness or injury to me, the Client, including death, that may result from or occur as a result of my participation in the Services, whether caused by negligence or otherwise. To the maximum extent permitted by law, this includes:

1. Any and all liability in contract, tort (including negligence), breach of statutory duty, or otherwise for any direct, indirect, special, incidental, or consequential costs, losses, claims, damages, expenses, or proceedings (including but not limited to loss of profits and wasted time) incurred or suffered by me arising directly or indirectly out of or in connection with our services, including but not limited to any loss, damage or expense arising from any defect, error, imperfection, fault, mistake or inaccuracy with the information or advice Practitioner provides.
2. Any and all liability for injury or loss arising out of the use of, or reliance on, the laboratory results and/or the dietary, supplement, and lifestyle suggestions the Practitioner may provide.
3. Any and all liability for injury or loss arising from any product I may choose to use.
4. Any and all liability for any failure to identify any medical condition or disease. I understand and agree that this is not the purpose of the services.
5. This is a comprehensive limitation of liability that applies to all damages of any kind, including (without limitation) compensatory, direct, indirect, or consequential damages, loss of data, income or profit, loss of or damage to property, and claims of third parties.

Name Printed	Signature	Date
_____	_____	_____

Notice of Privacy Practice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit a hospital, physician, dentist, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information often referred to as your health or medical record, serves as a basis for planning your care and treatment and serves as a means of communication among the many health professionals who contribute to your care. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and helps you make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS

Unless otherwise required by law, your health record is the physical property of the healthcare practitioner or facility that compiled it. However, you have certain rights with respect to the information.

You have the right to:

1. Receive a copy of this Notice of Privacy Practices from us upon enrollment or upon request.
2. Request restrictions on our uses and disclosures of your protected health information for treatment, payment, and health care operations. However, we reserve the right not to agree to the requested restriction.
3. Request to receive communications of protected health information in confidence.
4. Inspect and obtain a copy of the protected health information contained in your medical and billing records and in any other practice records used by us to make decisions about you. A reasonable copying charge may apply.
5. Request an amendment to your protected health information. However, we may deny your request for an amendment, if we determine that the protected health information or record that is the subject of the request:
    - was not created by us, unless you provide a reasonable basis to believe that the originator of the protected health information is no longer available to act on the requested amendment;
    - is not part of your medical or billing records;
    - is not available for inspection as set forth above; or
    - is accurate and complete.

    In any event, any agreed upon amendment will be included as an addition to, and not a replacement of, already existing records.
6. Receive an accounting of disclosures of protected health information made by us to individuals or entities other than to you, except for disclosures:
    - to carry out treatment, payment, and health care operations as provided above;
    - to persons involved in your care or for other notification purposes as provided by law;
    - to correctional institutions or law enforcement officials as provided by law;
    - for national security or intelligence purposes;
    - that occurred prior to the date of compliance with privacy standards;
    - incidental to other permissible uses or disclosures;
    - that is part of a limited data set (does not contain protected health information that directly identifies individuals);
    - made to patient or their personal representatives;
    - for which a written authorization form from the patient has been received
7. Revoke your authorization to use or disclose health information except to the extent that we have already been taken action in reliance on your authorization, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer that obtained the authorization with the right to contest a claim under the policy.

OUR RESPONSIBILITIES

We are required to maintain the privacy of your health information. In addition, we are required to provide you with a notice of our legal duties and privacy practices with respect to the information we collect and maintain about you. We must abide by the terms of this notice. We reserve the right to change our practices and to make the new provisions effective for all the protected health information we maintain. If our information practices change, a revised notice will be mailed to the address you have supplied upon request. If we maintain a website that provides information about our patient/customer services or benefits, the new notice will be posted on that website. Your health information will not be used or disclosed without your written authorization, except as described in this notice. Except as noted above, you may revoke your authorization in writing at any time.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions about this notice or would like additional information, you may contact our Privacy Officer at the telephone or address below. If you believe that your privacy rights have been violated, you have the right to file a complaint with the practice's Privacy Officer or with the Secretary of the Department of Health and Human Services. We will take no retaliatory action against you if you make such complaints.

THE CONTACT INFORMATION FOR BOTH ARE INCLUDED BELOW

U.S. Department of Health and Human Services
Office of the Secretary
200 Independence Avenue, S.W. Washington, D.C. 20201
Tel: (202) 619-0257
Toll-Free: 1-877-696-6775

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