ANGEL KIDS PEDIATRICS
We care for your angels

CONSENT

At Angel Kids Pediatrics we support breastfeeding mothers by providing access to lactation counselors in-office. Our lactation counselors are trained, certified specialists that provide clinical assistance, teaching, coaching, and problem solving for breastfeeding moms and their babies. A lactation counselor can help with:

- Supply Issues
- Engorgement
- Over Supply
- Medication (Mother)
- Infections or yeast
- Nutrition Guidance
- Latch Issues
- Flat/Inverted Nipples
- Sore Nipples
- Adopting
- Fussy Baby
- Tongue Tie
- Jaundice
- Slow Weight Gain
- Multiples
- Premature
- Relactation
- Returning to Work

Please select from the following:

_____NO, I would like to OPT OUT for lactation services and/or treatment to be offered to me at my child's visits with Angel Kids.
By opting out of our lactation services, I understand that if my breastfed child is being seen and I have a breastfeeding concern, it will not be addressed at that visit by a lactation counselor and/or pediatric provider without filling out the appropriate paperwork. **(DO NOT FILL OUT THE REST OF THIS PACKET IF OPTING OUT)**

_____YES, I would like to OPT IN for lactation services and/or treatment to be offered to me at my child's visits with Angel Kids.
By opting in to our lactation services, you understand that the lactation counselor will be meeting with you. If your insurance allows, we will be collecting your personal information and insurance information to submit claims on your behalf.

MOTHER'S INSURANCE/BILLING INFORMATION: (You must provide your current insurance card.)

Insurance: _____ □ **Private** □ **Medicaid** □

Policy#: _____ **Other/Self Pay Group#:** _____

Name of Primary Insured: _____

Name/Address of Employer: _____

AUTHORIZATION OF TREATMENT AND ASSIGNMENT OF BENEFITS:

I authorize Angel Kids Pediatrics (AKP) to treat myself and/or my child. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to AKP for any and all medical or surgical benefits otherwise payable to me under the terms of my insurance. I also affirm that I will reimburse AKP for any payments my insurance company may have sent to me in error. **I understand that I am financially responsible for all co-payments and any charges not covered under my insurance benefits.** I also understand that I am responsible for advising AKP of any and all changes to my insurance. Payment of co-pays

are due on date of service.

Signature:_____ Date: _____

MOTHERS INFORMATION

Name: _____

Date of Birth_____ Age: _____

Address: _____

City/State/Zip Code:_____

Phone: Home _____ Cell _____

Email: _____

Mother's OB/Midwife:_____

Baby's Name: _____

Baby's Date of Birth: _____ Birth weight: _____

Gestational age at birth: _____ wks. Age today: _____

Birth hospital/location: _____

REASON FOR VISIT

HAVE YOU EXPERIENCED OR ARE YOU CURRENTLY EXPERIENCING/CONCERNED ABOUT ANY OF THE FOLLOWING?

☐Nipple pain/cracks/injuries ☐Internal breast pain ☐Painful latch / feedings ☐Engorgement
☐Plugged ducts ☐Mastitis ☐Milk blister ☐Inadequate milk production
☐Using a nipple shield to nurse ☐Supplementing, despite intention to exclusively breastfeed ☐Pumping concerns / difficulty
☐Postpartum anxiety/depression concerns

HAS YOUR BABY EXPERIENCED OR IS YOUR BABY EXPERIENCING ANY OF THE FOLLOWING?

☐Excessive weight loss in first week of life ☐Inadequate weight gain ☐Infrequent stools (2 or less a day) ☐Mucousy stools
☐Unable to latch ☐Difficulty latching ☐Seems to prefer bottle ☐Does not latch deeply
☐Latches deeply, then slips down ☐Clamping/biting on nipple ☐Clicking while feeding ☐Prefers one breast ☐☐L ☐☐R
☐Sleepy at breast/must be stimulated ☐Fussing/crying during feedings ☐Choking/gagging during feedings ☐Congested after feedings
☐Frequent restlessness/seems unsatisfied ☐Unusually long feedings ☐ Unusually frequent feedings
☐Frequent hiccups /gassiness/spitting up ☐Persistent white coating on tongue
☐Noisy breathing/grunting/wheezing during feedings or when at rest

In your own words, describe any other reason for this visit:

_____

_____

_____

YOUR HEALTH / PREGNANCY / BIRTH / POSTPARTUM HISTORY:

HAVE YOU EVER HAD, BEEN TESTED, DIAGNOSED WITH:

☐Anemia ☐Allergies/Asthma ☐High Blood Pressure
☐Diabetes ☐Thyroid disorders ☐Depression
☐Anxiety ☐Pituitary disorder ☐Vitamin deficiency
☐Cancer ☐Eating Disorders ☐Venereal disease
☐Heart Disease ☐Weight Loss Surgery ☐Gastrointestinal disorders

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

☐ Breast Reduction; year _____ ☐Implants; year: _____

☐Lift; year _____ Biopsy; ☐L ☐R year: _____

☐Lumpectomy; ☐L ☐R year: _____

☐Nipple piercing: ☐L ☐R

Other surgeries/injuries in the nipple/areola/chest area? _____

How many pregnancies have you had? _____

How many live births? _____

If you have other children, were they breastfed?

Child 1 age: _____ ☐Yes; how long? _____ ☐No

Describe any breastfeeding difficulties: _____

Child 2 age: _____ ☐Yes; how long? _____ ☐No

Describe any breastfeeding difficulties: _____

Child 3 age: _____ ☐ Yes; how long? _____ ☐No

Describe any breastfeeding difficulties: _____

INFANT HEALTH / BEHAVIOR / CARE

Did baby have any of the following during or after birth?

☐ Breech presentation ☐ Low blood sugar ☐ Jaundice
☐ Umbilical cord around neck
☐ Meconium aspiration ☐ Breathing difficulties

If you experienced infertility/assisted conception, please describe medications/procedures used: _____

Did you have any of the following during this pregnancy? ☐ Anemia
☐Urinary/Other infection ☐Gestational diabetes
☐High Blood Pressure ☐Other_____

Type of delivery with this birth? ☐Vaginal (went into labor)
☐Vaginal (following induction) ☐Assisted Vaginal (vacuum/forceps)
☐VBAC ☐Unplanned Cesarean Birth ☐Planned Cesarean Birth

Reason for Induction/Cesarean: _____

Any of the following during this labor and delivery? ☐Antibiotics
☐Premature labor/rupture of membranes ☐Epidural ☐Spinal
☐Excessive bleeding

Drugs to induce or speed labor: _____

Other complication: _____

Any of the following postpartum complications?

☐Retained placenta
☐Urinary/Other infection ☐Low/High blood pressure
☐Hemorrhage requiring blood transfusion

Are you still experiencing postpartum bleeding?
☐No ☐Yes, light ☐Yes, moderate ☐Yes, heavy

Breast changes since birth? ☐None ☐Minor changes ☐Engorgement

Day milk "came in": _____ days postpartum

Taking any of the following? ☐Prenatal/Multi vitamin
☐DHA supplement ☐Probiotic ☐Antibiotics ☐Stool softener

☐Laxative ☐Antacid ☐Iron supplements ☐Depression / Anxiety meds
☐Placenta pills

☐Pain medication (name/dose// frequency):
_____

FEEDING/PUMPING HISTORY MANAGEMENT

Birth through Day 3: ☐Exclusively breastfed ☐Formula and Breast Milk ☐Only Formula
Reason for supplementation: _____

Currently: ☐Exclusively Breastfed ☐Breast Milk and Formula ☐Only Formula
Reason for supplementation: _____

Is baby waking on his/her own for feedings? ☐All feedings ☐Most feedings ☐Some feedings ☐Must wake for all feedings
In the past 24 hours, how many times has your baby fed? _____

How many of these feedings were at the breast? _____

Is baby taking both breasts each breastfeeding? ☐Yes ☐No; baby is not interested in 2nd side ☐No; I'm not offering 2nd side

Is your baby receiving bottles: ☐Yes, daily ☐Yes, occasionally ☐No Number of bottles in last 24 hrs.

If your baby is receiving formula, what brand: _____ Total ounces of formula a day: _____ oz.

Total given daily by bottle (pumped breastmilk and formula): _____ oz.

Are you pumping: ☐Yes, daily; number of times/day? _____ ☐Occasionally ☐Tried it a time or two ☐ No
If pumping, what type of pump you are using? ☐Manual ☐Rental ☐Personal use single electric ☐Personal use double electric

Pump brand/model: _____

Pump source: ☐New; retail purchase ☐New; provided by insurance ☐Used by me with older child ☐Used by another person prior to me

How long do you pump each session? _____min

How much milk are you expressing per session? _____oz.

What size flanges are you using? ☐Standard (came with the pump) ☐Small (purchased separately) ☐Large (purchased separately)

Does one breast produce significantly more milk? ☐Yes; ☐ R ☐ L ☐ No

BREASTFEEDING HELP HISTORY & GOALS

What are your breastfeeding goals? _____

_____

Is there anything else you want me to know? _____

_____