



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
- Supplementation
- Returning to Work

Please select from the following:

_____ **ACCEPT**, 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: _____

_____ **DECLINE**, 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)**

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?

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Nipple pain/cracks/injuries | <input type="checkbox"/> Internal breast pain | <input type="checkbox"/> Painful latch / feedings | <input type="checkbox"/> Engorgement |
| <input type="checkbox"/> Plugged ducts | <input type="checkbox"/> Mastitis | <input type="checkbox"/> Milk blister | <input type="checkbox"/> Inadequate milk production |
| <input type="checkbox"/> Using a nipple shield to nurse | <input type="checkbox"/> Supplementing, despite intention to exclusively breastfeed | | <input type="checkbox"/> Pumping concerns / difficulty |
| <input type="checkbox"/> Postpartum anxiety/depression concerns | | | |

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

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

- | | | |
|--|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Allergies/Asthma | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid disorders | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Pituitary disorder | <input type="checkbox"/> Vitamin deficiency |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Weight Loss Surgery | <input type="checkbox"/> Gastrointestinal disorders |

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?

- | | |
|---|--|
| <input type="checkbox"/> Retained placenta | |
| <input type="checkbox"/> Urinary/Other infection | <input type="checkbox"/> Low/High blood pressure |
| <input type="checkbox"/> Hemorrhage requiring blood transfusion | |

Are you still experiencing postpartum bleeding?

- | | | | |
|-----------------------------|-------------------------------------|--|-------------------------------------|
| <input type="checkbox"/> No | <input type="checkbox"/> Yes, light | <input type="checkbox"/> Yes, moderate | <input type="checkbox"/> Yes, heavy |
|-----------------------------|-------------------------------------|--|-------------------------------------|

Breast changes since birth? None Minor changes Engorgement

Day milk "came in": _____ days postpartum

Taking any of the following? Prenatal/Multi vitamin

- | | | | |
|---|------------------------------------|---|--|
| <input type="checkbox"/> DHA supplement | <input type="checkbox"/> Probiotic | <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Stool softener |
| <input type="checkbox"/> Laxative | <input type="checkbox"/> Antacid | <input type="checkbox"/> Iron supplements | <input type="checkbox"/> Depression / Anxiety meds |
| <input type="checkbox"/> Placenta pills | | | |

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

- | | | |
|---|---|-----------------------------------|
| <input type="checkbox"/> Breech presentation | <input type="checkbox"/> Low blood sugar | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Umbilical cord around neck | | |
| <input type="checkbox"/> Meconium aspiration | <input type="checkbox"/> Breathing difficulties | |

INFANT HEALTH / BEHAVIOR / CARE

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

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? _____