

The Lactation Program  
4600 Hale Parkway, Suite 140  
Denver, CO 80220  
303.377.3016

OUTPATIENT REGISTRATION INFORMATION

Mother's Name \_\_\_\_\_

Birthdate \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

City/St \_\_\_\_\_ Zip \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email address \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Address of Employer \_\_\_\_\_ Phone \_\_\_\_\_

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Spouse or Next of Kin \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Address (if different from above) \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Address of Employer \_\_\_\_\_ Phone \_\_\_\_\_

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Infant's  
Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Gender \_\_\_\_\_

Birth Wt \_\_\_\_ lbs. \_\_\_\_ oz. Current Wt \_\_\_\_ lbs. \_\_\_\_ oz. Date of Current Wt \_\_\_\_\_

INFORMATION FOR LACTATION PROGRAM

How did you hear about or who referred you to our program? \_\_\_\_\_

REASON FOR CONSULT \_\_\_\_\_

The Lactation Program  
4600 Hale Parkway, Suite 140  
Denver, Colorado 80220  
303.377.3016

## CONSENT FOR TREATMENT

1. **Fees for Services.** The fee for consultation services is \$75 per hour, plus additional charges for supplies and equipment as needed. Payment is required from me at the time services are rendered and a receipt will be provided. I am solely responsible for informing my insurance company of any charges and attempting to obtain reimbursement. The Lactation Program is unable to file any insurance claims on my behalf.

2. **The usual length of appointments.** The initial visit typically lasts 1½ to 2 hours, and follow-up visit(s) require ½ to 1 hour, depending on the problem.

3. **Consultation evaluation.** During my consultation a Registered Nurse, International Board Certified Lactation Consultant will perform a limited breast exam not intended for cancer detection, an infant weight check, an observation of breastfeeding, and an evaluation of infant suck. A test-weighing procedure will be used to measure the infant's milk intake at the breast. An electric breastpump will be used after the feeding to express any remaining milk. My breastmilk supply will be evaluated. If necessary, recommendations to assist in increasing my milk supply will be made. Supplemental milk may be required to assure my baby receives adequate nutrition. I understand that no guarantees have been made to me as to the results of the consult and treatment plan.

4. **Medication Information.** I will inform the Lactation Consultant of all medications and supplements, prescription and over-the-counter, that I am taking or that I am giving my infant. I understand that the Lactation Consultant cannot prescribe medications. I understand that The Lactation Consultant may suggest medications in the course of my treatment and that I, in consultation with my physician, will decide whether to follow those suggestions. I understand that the long-term effects of some medications on my infant may be unknown at this time.

4. **Follow-up procedures.** My progress will be monitored by phone calls and one or more return appointments until the problem is resolved. Follow-up visits are billed at the rate of \$75 per hour. There is no charge for phone follow-up.

5. **The Lactation Program may need to communicate with either the mother's and/or the infant's primary care provider(s) or the Lactation Program's Medical Consultant.** All medical care for me and for my infant is to be provided by our primary healthcare provider(s). Our healthcare provider(s) will be contacted regarding the recommended treatment plan for any breastfeeding difficulties. I will sign an authorization to permit The Lactation Program to release confidential medical information contained in my record to my primary healthcare provider(s) and/or to my infant's primary health care provider. The Lactation Program also utilizes a board-certified pediatrician as a medical consultant. I may choose to sign an authorization to permit The Lactation Program staff to discuss my case with this consultant in the process of developing my treatment plan. This consultant will not provide any other medical care to me or my infant.

**6. The Lactation Program's commitment to training of nurses and physicians.** The Lactation Program participates in the training of medical students and healthcare professionals in matters related to breastfeeding and lactation. All trainees are required to sign a confidentiality agreement as a condition of receiving training. The Lactation Program will request my authorization to permit medical students and health care professionals receiving training at the Lactation Program to observe during my consultation and to discuss with my Lactation Consultant information about my care. I may refuse to provide this authorization.

**7. Consent to take photographs for teaching and other purposes.** A Lactation Consultant may ask to take a photograph of me and/or my infant during a consultation. The Lactation Program may use these photographs for teaching, consultation and other purposes. The Lactation Consultant will not take any photographs unless I have signed the Photographic Consent Form. I may refuse to provide my consent.

**8. The Lactation Program respects and protects our clients' privacy.** We take our responsibility to protect the privacy and confidentiality of client information very seriously. We maintain physical, electronic, and procedural safeguards that comply with applicable legal standards to store and secure information about you from unauthorized access, alteration, and destruction.

From time to time The Lactation Program may wish to contact you regarding updates about our program or with information related to breastfeeding. If you would like to limit the contact The Lactation Program has with you, please indicate this by checking the appropriate options below.

- Please do not contact me with information regarding your program or related breastfeeding information by mail.
- Please do not contact me with information regarding your program or related breastfeeding information by email.
- Please do not contact me with information regarding your program or related breastfeeding information by phone.

9. I will keep valuables with me. The Lactation Program is not responsible for loss or damage to valuables and personal items brought with me to the consultation.

BY SIGNING BELOW, I CERTIFY THAT I HAVE READ THIS DESCRIPTION OF THE LACTATION PROGRAM AND/OR HAD IT EXPLAINED TO ME, THAT I UNDERSTAND ITS CONTENTS, AND THAT I AM THE PATIENT, OR A PERSON DULY AUTHORIZED TO EXECUTE THIS DESCRIPTION AND ACCEPT ITS TERMS. I ALSO CERTIFY THAT I CONSENT TO TREATMENT AS DESCRIBED ABOVE.

**Signature:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

The Lactation Program  
4600 Hale Parkway, Suite 140  
Denver, CO 80220  
Phone: 303.377.3016 Fax: 303.355.2282

PHOTOGRAPHIC CONSENT FORM

Mother's Name \_\_\_\_\_

Infant's Name \_\_\_\_\_

I, \_\_\_\_\_, authorize the photographing or videotaping of myself (or of my above named infant) at The Lactation Program for clinical, scientific, promotional, or educational purposes. Such visual reproductions may be included in my medical record to document clinical care; may be used for education and training of physicians, medical students, and ancillary health professionals; may appear on materials to promote breastfeeding and/or The Lactation Program; or may be used in conjunction with manuscripts published in the medical or scientific literature. I understand that my name (or the name of my infant), or other identifying written information will not be used without my prior written consent.

I hereby certify that I have read and fully understand the above provisions.

\_\_\_\_\_  
Signature of Mother Date

\_\_\_\_\_  
Witness Date

**AUTHORIZATION FOR DISCLOSURE OF  
INFORMATION BY THE LACTATION PROGRAM**

1. **Authorization:** I hereby authorize The Lactation Program to disclose any information about me and/or about my infant created or received by The Lactation Program to my healthcare provider and to my infant's health care provider and their clinical staff.

Name/Practice of my obstetrician: \_\_\_\_\_

Name/Practice of infant's physician: \_\_\_\_\_

I also authorize The Lactation Program to disclose any information about me and/or my infant created or received by The Lactation Program to the individuals listed below (Please check all boxes that apply):

- To my spouse, significant other, or other immediate family member  
(Please print full name: \_\_\_\_\_).
- To The Lactation Program's Medical Consultant (pediatrician, Marianne Neifert, MD) for purposes of assisting The Lactation Program in providing care.
- To medical students and/or healthcare professionals who are receiving training from The Lactation Program. **By checking this box, I also am authorizing medical students and/or healthcare professionals to observe my consultations with a Lactation Consultant.**

2. **Revocation Rights:** I understand that I have the right to revoke, at any time, the authorization for any or all of the individuals listed above to receive information about me by sending a written notice of revocation to the Program Director, The Lactation Program, 4600 Hale Parkway, Suite 140, Denver, Colorado 80220. I understand that the revocation will become effective upon receipt. I understand that any information about me or about my infant disclosed pursuant to this Authorization before the effective date of a revocation will not be subject to the revocation.

3. **Further Disclosure:** I understand that once The Lactation Program discloses information about me or about my infant pursuant to this Authorization, The Lactation Program can not prevent further disclosure of that information without my consent.

4. **Expiration Date:** I understand that this Authorization will expire one year from the date indicated below.

5. I understand that I am entitled to receive a copy of this Authorization.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

**AUTHORIZATION FOR DISCLOSURE OF  
PROTECTED HEALTH INFORMATION**

To: My Obstetric Care Provider

To: My Infant's Physician

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Practice: \_\_\_\_\_

Practice: \_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

1. **Authorization:** I hereby authorize you to disclose all records relevant to my breastfeeding history to The Lactation Program, 4600 Hale Parkway, Suite 140, Denver, Colorado 80220, Attention: Clinical Staff.

2. **Purpose of the Disclosure:** To assist The Lactation Program in providing advice concerning breastfeeding and lactation.

3. **Revocation Rights:** I understand that I have the right to revoke this Authorization at any time by sending a written notice of revocation to the health care provider identified above. I understand that the revocation will become effective upon receipt. I understand that any PHI disclosed pursuant to this Authorization before the effective date of a revocation will not be subject to the revocation.

4. **Further Disclosure:** I understand that once the health care provider identified above discloses PHI pursuant to this Authorization, the PHI may no longer be protected under federal law, and the recipient may further disclose the PHI which it receives pursuant to this Authorization without my consent.

5. **Expiration Date:** I understand that this Authorization will expire one year from the date indicated below.

6. I understand that the health care provider listed above may not condition treatment on my signing this Authorization.

7. I understand that I am entitled to receive a copy of this Authorization.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

## Initial Intake Information Record

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Mother's Name: \_\_\_\_\_ Mother's Age: \_\_\_\_\_

1. Education: (please circle the appropriate level completed)  
 High School: <9   9   10   11   12   College:   13   14   15   16   17+
2. Are you: \_\_\_\_\_ Married  
 \_\_\_\_\_ Separated  
 \_\_\_\_\_ Divorced  
 \_\_\_\_\_ Single – Baby's father involved  
 \_\_\_\_\_ Single – Baby's father not involved
3. Have you ever been in therapy or received counseling for relationship issues or emotional problems? \_\_\_ No \_\_\_ Yes  
 If yes, please describe (when, for what period of time, for what problem): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Perinatal History:

4. Have you attended a prenatal class on breastfeeding?..... \_\_\_ Yes \_\_\_ No
5. How many times have you been pregnant? \_\_\_\_\_
6. How many children do you have? \_\_\_\_\_
7. Where did you (will you) deliver your baby? \_\_\_\_\_ Due Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_
8. How much weight did you gain during this pregnancy? \_\_\_\_\_ lbs.
9. Did you have any complications during this pregnancy, such as high blood pressure, anemia, premature labor, gestational diabetes, HELLP?..... \_\_\_ No \_\_\_ Yes
10. Did you have any difficulty conceiving?..... \_\_\_ No \_\_\_ Yes  
 If yes, please explain: \_\_\_\_\_
11. Do you have any history of irregular menstrual cycles? ..... \_\_\_ No \_\_\_ Yes
12. Have you ever been diagnosed with Polycystic Ovary Syndrome (PCOS)..... \_\_\_ No \_\_\_ Yes

### Maternal History:

13. Did you have any change in areola color during pregnancy? ..... \_\_\_ Yes \_\_\_ No  
 Comments: \_\_\_\_\_
14. Do you have a breast lump now? ..... \_\_\_ No \_\_\_ Yes  
 If yes, which breast? Right   Left  
 How long has the lump been there? \_\_\_\_\_
15. Have you had any leaking of colostrum with this pregnancy? ..... \_\_\_ Yes \_\_\_ No
16. Have you ever had breast surgery of any kind? ..... \_\_\_ No \_\_\_ Yes
17. If yes, please explain:

Date	Which Breast(s)?	Nature of Surgery
1.		
2.		
3.		

18. Describe the breastfeeding experiences of your immediate female relatives:

	Successfully Breastfed One or More Children	Had Problems with One or More Children (Explain)	Did Not Breastfeed Any Children	Not Known
1. Your mother's mother				
2. Your mother				
3. Sister 1				
4. Sister 2				
5. Sister 3				
6.				
7.				

19. Do you have any chronic medical conditions, such as a heart condition, thyroid condition, celiac disease, diabetes, etc.? ..... No \_\_\_ Yes  
If yes, please explain: \_\_\_\_\_
20. Are you currently taking prenatal vitamins? ..... Yes \_\_\_ No
21. Are you taking other vitamins, minerals, or supplements? ..... No \_\_\_ Yes  
If yes, please explain: \_\_\_\_\_
22. Are you currently taking any other medications? ..... No \_\_\_ Yes  
If yes, please explain: \_\_\_\_\_
23. Do you smoke? ..... No \_\_\_ Yes  
If yes, how many cigarettes per day? \_\_\_\_\_
24. Do you ever drink alcohol? ..... No \_\_\_ Yes  
If yes, how much and how often? \_\_\_\_\_
25. Do you ever use any recreational drugs? ..... No \_\_\_ Yes  
If yes, what drugs do you use? \_\_\_\_\_
26. Are you allergic to any medications? ..... No \_\_\_ Yes  
If yes, what? \_\_\_\_\_
27. Is there history of any of the following conditions in your baby's immediate family (you, your partner, either of your parents or siblings, or your baby's siblings)?:
- Milk intolerance..... No \_\_\_ Yes
  - Eczema..... No \_\_\_ Yes
  - Asthma..... No \_\_\_ Yes
  - Chronic skin condition..... No \_\_\_ Yes
  - Hay fever..... No \_\_\_ Yes
  - Allergies..... No \_\_\_ Yes
  - Insulin dependent diabetes..... No \_\_\_ Yes
  - Other: \_\_\_\_\_
28. Do you plan to return to work/school after delivery? ..... No \_\_\_ Yes  
If yes, when? \_\_\_\_\_
29. Is your husband/partner supportive of your desire to breastfeed?..... Yes \_\_\_ No

**Please complete if you have other children:**

30. Did you attempt to breastfeed any of your other children?..... Yes \_\_\_ No

Child's Name	Age	How Long Breastfed?	Any Breastfeeding Problems?	Reason for Stopping Breastfeeding

31. Did you have any difficulty making enough milk for any of your previous babies?..... No \_\_\_ Yes  
If yes, why do you think you had difficulty? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_





**24-hour Feeding and Pumping Log**

Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Days Old

Interval	Breastfeeding Session	Intake Measured by Test Weight	Pumped Volume (ml)		Supplement Volume (ml)		Urine (wet diapers)	Stool (dirty diapers)	Comments
			Left	Right	Breast	Formula			
12-1 am									
1-3 am									
3-4 am									
4-5 am									
5-6 am									
6-7 am									
7-8 am									
8-9 am									
9-10 am									
10-11 am									
11-12 noon									
12-1 pm									
1-2 pm									
2-3 pm									
3-4 pm									
4-5 pm									
5-6 pm									
6-7 pm									
7-8 pm									
8-9 pm									
9-10 pm									
10-11 pm									
11-12 midnight									
Total									