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Client Information and Informed Consent for Lactation Consultation

Mother's Name: _____ **Father's Name:** _____

Address: _____

Phone: (H) _____ **(W)** _____ **Email:** _____

Infant(s)' Name(s): _____ **Date of Delivery:** _____ **time** _____ **Place of Delivery:** _____
 _____ **Birth Weight:** _____ **most recent weight:** _____

PEDIATRICIAN: _____ **Address:** _____
Phone: _____ **Fax:** _____

OB/GYN, MD, DO, CNM: _____ **Address:** _____
Phone: _____ **Fax:** _____

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While the advice given by Lactation Consultants is effective in most instances: I understand the following: (Read, Initial, and Sign)

_____ The lactation consultant is an allied health care provider and responsible for evaluating and recommending a care plan to resolve or improve breastfeeding issues. A lactation visit includes: a detailed history of mother/infant, an assessment of maternal/infant anatomy, observation of a feeding for evaluation of technique and effectiveness of feeding, and recommendations for management to improve and/or resolve breastfeeding related issues. All clients are provided with a written and/or oral care plan to improve breastfeeding concerns. The client and the lactation consultant each have responsibilities in this plan. Resolution of a breastfeeding problem often takes several days or weeks and may require a change in the original recommended care plan at some point.

_____ I am responsible for informing the lactation consultant of changes I feel are necessary in the care plan at the time of the visit or during the course of follow-up communications. Phone contact during the time following the lactation visit is crucial and considered an extension of your visit. **I understand it is my responsibility to call the lactation consultant with progress reports, questions or concerns.**

_____ Any change from my physician's recommendations should be discussed with the physician. Health care issues of a medical nature **MUST** be discussed with a physician.

_____ A partial or follow-up visit is sometimes necessary. I understand that breastfeeding supplies and/or breast pumps may be recommended as effective management of specific situations. Only effective equipment will be recommended.

_____ I hereby authorize the lactation consultant to release any information acquired in the evaluation and/or management of myself and/or my child to our health care providers, referring physician, referring lay breastfeeding counselor, and/or our insurance company upon request. I understand the lactation consultant may contact my physician or my child's physician if the lactation consultant feels it is necessary to consult with the physician.

_____ I give permission for information, photos and/or videos of my lactation visit to be used in lactation articles or studies for professional education.

_____ I have received a copy of this provider's Privacy Practices.

_____ I understand this practice accepts only **fee for service at time of service**. It is my responsibility to pursue reimbursement for lactation services from my insurance company. This practice does no billing for insurance reimbursement and is not a provider on any insurance plan. Reimbursement is not guaranteed, but filing is suggested.

*Charges:

Consultations are \$100.00 for the first hour or part thereof and \$25.00 for each additional quarter hour or part thereof.

*Travel costs will incur if place of visit is greater than 10 miles from my home in Wilton.

*Weekend and/or Holiday fee is an additional \$25.00.

This form has been fully explained to me and I certify that I have read and understand the contents.

Date: _____

Signature: _____