

## BREAST FEEDING PEER COUNSELOR HOSPITAL LACTATION SPECIFIC CLIENT CONTACT

WIC Site/ County: \_\_\_\_\_ Room: \_\_\_\_\_  
 Initial visit by: \_\_\_\_\_ Date: \_\_\_\_\_  
 Follow-up visit by: \_\_\_\_\_ Date: \_\_\_\_\_

Circle Feeding Method: Breastfeeding    Pumping    Formula Feeding    Type: \_\_\_\_\_  
 BF goals: \_\_\_\_\_ BF History: \_\_\_\_\_

### Mother's Information

Name: \_\_\_\_\_ Age: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone Number(s) \_\_\_\_\_ WIC ID# \_\_\_\_\_

### Maternal History (check all that apply)

<input type="checkbox"/>	Diabetic Insulin Dependent	<input type="checkbox"/>	Diabetic Non Insulin Dependent
<input type="checkbox"/>	Drug/Alcohol Abuse	<input type="checkbox"/>	Smoking
<input type="checkbox"/>	Hyperthyroidism	<input type="checkbox"/>	Hypothyroidism
<input type="checkbox"/>	Breast Trauma/ Surgeries	<input type="checkbox"/>	other (specify)

### Breasts: (check all that apply)

size:	<input type="checkbox"/>	Small	<input type="checkbox"/>	Medium	<input type="checkbox"/>	Large	<input type="checkbox"/>	X-Large	<input type="checkbox"/>	other:
	<input type="checkbox"/>	Soft	<input type="checkbox"/>	Filling	<input type="checkbox"/>	Full	<input type="checkbox"/>	Engorged	<input type="checkbox"/>	other:

### Nipples: (check all that apply)

size:	<input type="checkbox"/>	Small	<input type="checkbox"/>	Medium	<input type="checkbox"/>	Large	<input type="checkbox"/>	X-Large	<input type="checkbox"/>	other:			
<input type="checkbox"/>	Everted	<input type="checkbox"/>	Everted w/ pinch	<input type="checkbox"/>	Inverted R / L with pinch	<input type="checkbox"/>	Tender	<input type="checkbox"/>	Pink / reddened				
<input type="checkbox"/>	Cracked	<input type="checkbox"/>	Creased	<input type="checkbox"/>	Flat R / L	<input type="checkbox"/>	Bleeding	<input type="checkbox"/>	Bruised	<input type="checkbox"/>	Scabbed	<input type="checkbox"/>	Blisters

### Baby's Information

DOB: \_\_\_\_\_ Weeks Gestation: \_\_\_\_\_ Sex: M    F  
 Baby's Name: \_\_\_\_\_ Apgar Score: \_\_\_\_\_  
 Birth weight: \_\_\_\_\_ pounds \_\_\_\_\_ grams    Birth length: \_\_\_\_\_  
 Pediatrician: \_\_\_\_\_ Group B Strep: Yes    No

### Infant Assessment: (check all that apply)

<input type="checkbox"/>	Asleep	<input type="checkbox"/>	Drowsy	<input type="checkbox"/>	Alert	<input type="checkbox"/>	Fussy	<input type="checkbox"/>	Tongue extends past lower gum
<input type="checkbox"/>	Chin recedes	<input type="checkbox"/>	Frenulum Short	<input type="checkbox"/>	other:				

### Digital Suck Exam: (check all that apply)

<input type="checkbox"/>	Normal	<input type="checkbox"/>	Absent	<input type="checkbox"/>	Depressed	<input type="checkbox"/>	Strong / rhythmic	<input type="checkbox"/>	Frantic/ disorganized
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### Feeding Assessment: (check all that apply)

Attachment:	<input type="checkbox"/>	Adequate	<input type="checkbox"/>	Shallow	<input type="checkbox"/>	Difficult	<input type="checkbox"/>	None
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### Suck Assessment: (check al that apply)

<input type="checkbox"/>	Nutritive / audible swallow	<input type="checkbox"/>	Non-nutritive suckling	<input type="checkbox"/>	Weak	<input type="checkbox"/>	Attached-not suckling
<input type="checkbox"/>	Starts / stops repeatedly	<input type="checkbox"/>	No latch	<input type="checkbox"/>	other:		

### Type of delivery:

<input type="checkbox"/>	<b>Vaginal</b>	<input type="checkbox"/>	Induced	<input type="checkbox"/>	Pitocin	<input type="checkbox"/>	<b>Cesarean</b>	<input type="checkbox"/>	Scheduled	<input type="checkbox"/>	Emergency	<input type="checkbox"/>	Vacuum
<input type="checkbox"/>	Forceps	<input type="checkbox"/>	Epidural	<input type="checkbox"/>	Stadol	<input type="checkbox"/>	Magnesium Sulfate	<input type="checkbox"/>	other:				

