BREAST FEEDING PEER COUNSELOR HOSPITAL CLIENT CONTACT

Mother's Information
Name: _____ Age: _____
Address: _____
Phone Number(s)_____ WIC ID#_____

Maternal History and Previous Breastfeeding Experience
_____
_____
_____

Previous Breastfeeding experience:	Sore Nipples:
Positioning: correct/needs assist	Health problems/meds?

Baby's Information
DOB: _____ Weeks Gestation: _____ Sex: M F
Baby's Name: _____
Birth weight: _____pounds_____grams Birth length: _____
Pediatrician: _____

Latch on: good/needs help	How often does baby nurse?
How long do feedings last?	Health problems/meds?

Attending OB/GYN Doctor: _____
Information Given:

Topics discussed at visit:

_____ Normal nursing patterns, including frequency and duration of each feeding *(nurse often, no limits of frequency, cluster feedings, growth spurts*)
_____ Engorgement
_____ Normal maternal feelings when breastfeeding (*drowsiness, uterine contractions, thirst)*
_____ Baby's bowel movements and wet diaper count
_____ Baby's weight loss / gain
_____ Tips for waking a sleepy baby

_____ Proper positioning
_____ How to break baby's suck
______ Baby's stomach capacity (Day 1= 5-7ml, Day 3= 22-27ml, Day 10 = 45-60ml) 30ml = 1oz
_____ Pumping Tips
_____ Importance of mother-baby togetherness
_____ AAP endorses breastfeeding

Date	Narrative Documentation of Contacts