



## LACTATION CONSULTATION CONSENT FORM

<b>MOTHER</b>	<p>_____ _____ _____ _____</p> <p>Your Name                                      Your Birth Date                      Your Age                      Your Profession</p>			
	<p>_____ _____</p> <p>Street Address                                      City                                      State                      Zip</p>		<p>_____ _____</p> <p>Partner's Name                                      Partner's Profession</p>	
	<p>_____ _____</p> <p>Phone (home/landline)                      Phone (cell) Do you text? <input type="checkbox"/> Yes <input type="checkbox"/> No                      Email</p> <p style="text-align: center;"><i>Note that text messages are not secure and cannot protect your private health information (PHI)</i></p>			
	<p>How would you prefer to receive the report from this consult?    <input type="checkbox"/> Email    <input type="checkbox"/> Regular Mail    <input type="checkbox"/> Faxed To: _____</p>			
	<p>Referred by:    <input type="checkbox"/> Friend/Family: _____    <input type="checkbox"/> Hospital: _____    <input type="checkbox"/> Doctor: _____</p>			
	<p>Website: <input type="checkbox"/> _____    <input type="checkbox"/> Internet search    <input type="checkbox"/> Other referral source: _____</p>			
<b>BABY</b>	<p>_____ _____ _____ _____</p> <p>Baby's Full Name                                      Sex: <input type="checkbox"/> M <input type="checkbox"/> F                      Due Date                      Birth Date                      Weeks Gestation at Birth</p>			
	<p>_____ _____</p> <p>Place of Birth                                      City/State of Birth</p>			
<b>INSUR- ANCE</b>	<p>_____ _____</p> <p>Insurance Company                                      Primary Insured's Name</p>			
	<p>_____ _____</p> <p>Employer                                      Date of Birth                      <input type="checkbox"/> Self    <input type="checkbox"/> Spouse    <input type="checkbox"/> Other</p> <p style="text-align: right;">Relationship to Mother</p>			
	<p>Member Number: _____</p>		<p>Group Number: _____</p>	
<b>HEALTH CARE PROVIDERS</b>	<b>OBSTETRICIAN / MIDWIFE</b>		<b>PEDIATRICIAN</b>	
	<p>_____ _____</p> <p>Name                      Send report? <input type="checkbox"/> No    <input type="checkbox"/> Yes (provide following info):</p>		<p>_____ _____</p> <p>Name</p>	
	<p>_____ _____</p> <p>City and State</p>		<p>_____ _____</p> <p>City and State</p>	
	<p>_____ _____</p> <p>Phone</p>		<p>_____ _____</p> <p>Phone</p>	
	<p>_____ _____</p> <p>Fax or Email</p>		<p>_____ _____</p> <p>Fax or Email</p>	
<p><b>I understand that:</b></p> <ul style="list-style-type: none"> <li>• All medical care is to be provided by my own physician(s) and that any change from his/her/their recommendations should be discussed with him/her/them.</li> <li>• A lactation consultation by the IBCLC may include a visual and manual assessment of the mother's breasts, the baby's mouth and suck, observation of the mother and baby breastfeeding, analysis of information relating to the breastfeeding situation, demonstration of techniques for improving breastfeeding, use of breastfeeding equipment, and recommendation of a care plan to resolve breastfeeding issues, which may be adjusted during the course of treatment.</li> <li>• A student intern may accompany the IBCLC and participate in the consultation for training purposes.</li> <li>• I am responsible for informing the lactation consultant(s) of any relevant information or changes that affect my breastfeeding situation.</li> <li>• <i>It is my responsibility to call the lactation consultant(s) with progress reports, questions, or concerns.</i></li> <li>• This practice will submit a claim for direct payment of insurance benefits with participating insurance companies and bill me for any remaining co-pay or fees. For those who are not insured or who are insured with companies with which we do not participate, payment for services and supplies are my sole responsibility and required at the time of service; a receipt will be provided for insurance reimbursement.</li> </ul>				
<p><b>I grant consent for:</b></p> <ul style="list-style-type: none"> <li>• Information about this consultation to be mailed, faxed, or emailed to my attending physician/health care providers.</li> <li>• The release of any medical information necessary to process any insurance claim(s) and payment of any insurance benefits directly to this practice.</li> <li>• Information from this consultation to be used for teaching purposes, with the understanding that no names or identifying features will be used.</li> <li>• Treatment according to the scope of practice outlined above.</li> </ul>				
<p><b>My signature below acknowledges my understanding of the conditions set forth above.</b></p>				
<p>_____ _____</p> <p>Client Signature</p>		<p>_____ _____</p> <p>Date</p>		
<p>I give permission for photos and/or videos of my lactation visit to be taken and used solely for educational purposes, including presentations at professional conferences and workshops without further notice or compensation. No identifying information will be present in any photograph or video.</p>				
<p>_____ _____</p> <p>INITIALS</p>				