



Breastfeeding Assessment and Counseling Form

Counselor Information		
Counselor Name:		Clinic Site/Facility:
Date of consultation:	Type: <input type="checkbox"/> In person <input type="checkbox"/> By telephone	Place: <input type="checkbox"/> Hospital <input type="checkbox"/> Clinic <input type="checkbox"/> Home

Mother Information			
Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other	WIC FID/PAN #:	Preferred Phone #:	
Mother's Name:	DOB:	Alternate contact:	
Date of delivery:	Delivery Hospital:	Method: <input type="checkbox"/> Vag <input type="checkbox"/> C-sec	Medicated delivery: <input type="checkbox"/> Y <input type="checkbox"/> N
# of previous children	# of previous children breastfed	*Avg. length of BF	
Previous breast surgeries <input type="checkbox"/> Y <input type="checkbox"/> N	Current maternal medications:		
History of breastfeeding problems:			
How is breastfeeding going for mom and infant?			
Using breast pump? <input type="checkbox"/> Y <input type="checkbox"/> N If yes, type and frequency of pumping:			
Returning to work/school: <input type="checkbox"/> Y <input type="checkbox"/> N	Date Returning:		

Check all that apply:

Milk Supply	Nipple/Areola Assessment (Visual or verbal)	Breast Assessment
<input type="checkbox"/> Colostrum	Pain/soreness <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> extreme	<input type="checkbox"/> Pain in breasts
<input type="checkbox"/> WNL for days postpartum	Engorgement <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> extreme	<input type="checkbox"/> Engorgement
<input type="checkbox"/> Low milk supply	Blistered/cracked/bleeding <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> extreme	<input type="checkbox"/> Softer after feeding
<input type="checkbox"/> Over-abundant milk supply	Everted/flat/inverted	<input type="checkbox"/> Mastitis/Inflammation <input type="checkbox"/> Fever/Flu Symptoms
	Everts: <input type="checkbox"/> at rest <input type="checkbox"/> with stimulation	<input type="checkbox"/> Redness
	<input type="checkbox"/> Other:	<input type="checkbox"/> Lump/Mass
		<input type="checkbox"/> Plugged duct
		<input type="checkbox"/> Other



left breast



right breast

Infant Information

Infant name:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Wks gestation:	DOB:	Birth weight:	Birth length:
Home from hospital? <input type="checkbox"/> Y <input type="checkbox"/> N	Age today:	Current weight:	Current length:	Growth: low/*WNL		
How often does baby nurse in 24 hrs?		How long does each feeding last? (1 side or both)	Who ends feeding? <input type="checkbox"/> Baby <input type="checkbox"/> Mom			
Does baby get <input type="checkbox"/> formula <input type="checkbox"/> water <input type="checkbox"/> juice <input type="checkbox"/> solids <input type="checkbox"/> other? What/how much each day?						
# of wet diapers in 24 hours?	# of dirty diapers in 24 hours?	Color of dirty diapers?	Any current health problems/medications?			

How would you categorize the baby's level of alertness?

awake alert very active fussy very passive sleepy lethargic Notes:

Feeding behavior, position and latch (visual or verbal)

<input type="checkbox"/> Ears, shoulders, hips in alignment	<input type="checkbox"/> Chin indents breast	<input type="checkbox"/> Audible swallowing	<input type="checkbox"/> Circular movement of jaw
<input type="checkbox"/> Nipple confusion	<input type="checkbox"/> Cries at the breast	Falls off breast: <input type="checkbox"/> during feed <input type="checkbox"/> end of feed	<input type="checkbox"/> Stays attached & sleeps, no sucking
<input type="checkbox"/> Feeds on nipple, not areola	<input type="checkbox"/> Lips not flanged <input type="checkbox"/> Lips flanged	<input type="checkbox"/> Cheeks dimpling <input type="checkbox"/> Cheeks rounded	<input type="checkbox"/> Other:

Returning to Work/School

Date returning: <input type="checkbox"/> FT <input type="checkbox"/> PT	Hours of mom/infant separation, including travel time: _____ per day	Supportive employer? <input type="checkbox"/> Y <input type="checkbox"/> N
Accessible place to store milk? <input type="checkbox"/> Y <input type="checkbox"/> N	Access to private place to pump? <input type="checkbox"/> Y <input type="checkbox"/> N	Accessible place to clean pump equipment? <input type="checkbox"/> Y <input type="checkbox"/> N

Assistance Provided During Consult

Latch Positioning Other:

Supplies Provided

Shields-size XL pump flange Pads Bra Shells SNS Other:

Type of pump issued: _____ Reason for pump issuance: _____

Additional Education

<input type="checkbox"/> Signs of good/bad latch	<input type="checkbox"/> Hunger/satiety cues	<input type="checkbox"/> Skin-to-skin care	<input type="checkbox"/> Establishing milk supply
<input type="checkbox"/> Diaper counts	<input type="checkbox"/> Nipple care	<input type="checkbox"/> Milk storage	<input type="checkbox"/> Breast care/engorgement
<input type="checkbox"/> Pumping	<input type="checkbox"/> Return to work/school	<input type="checkbox"/> Medications and BF	<input type="checkbox"/> Prenatal education items
<input type="checkbox"/> Other			

Referrals

LA IBCLC Support Group (WIC/LLL) Pediatrician OB Clinic/ER Other

Follow-up? Y N In person: Y N Follow-up date _____ Specific issue: _____
 Y N Courtesy call: Y N

I give permission to the Breastfeeding Specialist to counsel and examine me in breastfeeding my baby. I understand that this counseling session may involve direct contact to my breast in order to ensure correct positioning and breast attachment.

Yo doy permiso a la consejera especializada en la lactancia materna para aconsejarme y examinarme en cómo alimentar con el pecho a mi bebé. Yo entiendo que durante la sesión existe la posibilidad del contacto directo con mi seno para poder asegurar la posición correcta del bebé al pecho.

Participant's Signature/Firma de Participante: _____ Date/Fecha: _____

Counselor's Signature: _____ Date: _____

*WNL – abbreviation for Within Normal Limits
 *Avg. abbreviation for Average
 ABM – artificial baby milk
 BID – twice a day
 c – with
 C/O – complaints of
 C/S – cesarean section
 DBF – direct breast feed
 EBM – expressed breast milk
 ELBW – extremely low birth weight <1000 grams or < 2# 3oz
 FNA – fine needle aspiration
 FTT – failure to thrive

HS – at bedtime
 HX – history
 IDM – infant of diabetic mother
 IUGR – intrauterine growth restriction
 LBW – low birth weight <2500 grams or <# 8 oz
 LGA – large for gestational age
 P 1 G 1 – Para one and gravida one
 PP – post partum
 PPD – post partum depression
 QID – four times a day
 QNS – quantity not sufficient
 QS – quantity sufficient
 RX – prescription

s – without
 SGA – small for gestational age
 SIDS – sudden infant death syndrome
 STS – skin to skin
 SX – symptom
 TID – three times a day
 TX – treatment
 U/S – ultra sound
 VAVD – vacuum assisted vaginal delivery
 VD – vaginal delivery
 VLBW – very low birth weight <1500 grams or <3# 5 oz
 > – greater than
 < – less than

