Breastfeeding at Full Circle

Mother's Information

Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email _____ Marital Status: M S W D

Baby's Information

First name_____ Last Name _____ Date of Birth _____

Insurance

Mother's Insurance Company Name _____

Member ID # _____ Group # _____

Name of Primary Insured _____ Primary Insured's Date of Birth _____

Mother's Relationship to Primary Insured: __ Self __ Spouse __ Child

Baby's Insurance Company Name __ Same as Mother's __ Other: _____

If Other: Member ID # _____ Group # _____

Name of Primary Insured _____ Primary Insured's Date of Birth _____

Baby's Relationship to Primary Insured: _____

Emergency Contact

Contact Name _____ Phone _____ Relationship _____

Pharmacy

Pharmacy Name _____ Phone _____

How did you hear about Breastfeeding at Full Circle? _____

Breastfeeding at Full Circle

Patient Consent Form

I, _____ understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers, who may be involved in that treatment directly and indirectly
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have been given by you, your Notice of Privacy Practices, containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Signature: _____ Date: _____

I understand that a consultation will include a visual and manual examination of my-self and my infant including my breasts and my infant's mouth. I give permission for information from this and subsequent consultations to be shared with my child's pediatrician, my own health care providers and my insurance company. I give permission for information from this consultation visit to be used to further the knowledge of breastfeeding. I understand that no specific names will be publicly used.

Patient Signature: _____ *Date:* _____

1241 Mamaroneck Avenue White Plains, NY 10605 (914)-421-1500

Mother's Name _____ **Baby's Name** _____

Peditrician's Name _____

Pediatric Practice _____ Location _____

Hospital where baby was born _____ Birth Weight _____ Discharge Weight _____

Reason for visit _____

Is anyone else assisting you with this concern?_____

Family History

Other children's ages _____ How long did they breastfeed? _____

Family history of allergies? If yes, explain _____

Recent history of illness/injury/surgery, other than birth? If yes, explain _____

_____

Do you take medications? If so, please list _____

Have you ever had: __ Miscarriage __ Anemia __ Allergy/Asthma __ Depression __ Dermatitis

__ Diabetes __ Excema __ Polycystic Ovarian Syndrome __ Thyroid Disorder __ Yeast infection

Have you ever had procedures on your breasts?

__ Biopsy __ Lump __ Implants __ Breast Reduction __ Other Surgery: _____

Procedure _____ Year _____ __ Left Breast __ Right Breast

Procedure _____ Year _____ __ Left Breast __ Right Breast

Procedure _____ Year _____ __ Left Breast __ Right Breast

Pregnancy History

__ Planned __ Surprise __ Fertility Problems _____

Weight Gain _____ Feelings about pregnancy _____

_____

Did your breasts change during the pregnancy? _____

During the pregnancy, did you experience:

__ Premature Labor __ Gestational Diabetes __ High Blood Pressure __ GBS

Medications during labor _____

Birth

__ Vaginal __ Cesarean __ Vacuum Extraction __ Forceps __ Hemorrhage

How many weeks were you pregnant? ____ Feelings about labor and birth _____

_____

Postpartum

Mother: __ Hemorrhage __ Infections: If yes, explain _____

__ High blood pressure __ Medications: If yes, please list _____

Baby: Was the baby jaundiced? _____ Did the baby have low blood sugar? _____

If so, what treatment was given? _____

Did the baby have any other health problems? _____

Breastfeeding in the hospital

How soon after birth did the baby latch? _____

Was the baby supplemented in the hospital? _____ Was the baby given a bottle in the hospital? _____

Home

Are you using a breast pump? _____ How often? _____ Why? _____

How many times in the past 24 hours has the baby nursed? _____

Is the baby receiving supplementation? __ Expressed breast milk __ Formula

How is the baby supplemented? __ Bottle __ Cup __ SNS __ Finger feed

How many times was the baby supplemented in the past 24 hours? _____ How many ounces? _____

How many wet diapers in the past 24 hours? _____ How many dirty diapers? _____ Color _____

Is the baby on any medications? If yes, please list _____

Home Life

Do you have help at home? _____

Partner's feelings _____

Are you eating? _____ Drinking plenty of fluids? _____ Resting? _____

Are you returning to work? _____ If yes, when? _____

What are your breastfeeding goals?_____