Date: ______________

IBCLC CONSULTATION REPORT

Lactation Consultant Name ____

Lactation Consultant Phone/ Email ____

□ Phone □ In office □ Virtual

Lactating Parent: __________________________ **Age:** ____________ **Phone Number:** __________________

Baby: __________________________ □ **M** □ **F** **DOB:** ____________ **Today's Age:** ______________

Breastfeeding Goal(s): ____

Feeding Concern(s): ____

Infant Assessment

□ Weight gain: ________________________________

□ Output: ____________________________________

□ Upper body Eval: ____________________________

□ Oral cavity: ________________________________

□ Medical: __________________________________

□ Latch: ____________________________________

□ Other: ____________________________________

____

Maternal Assessment

□ History: ____________________________________

□ Medical: ____________________________________

□ Milk supply: ________________________________

□ Breast Eval: ________________________________

□ Nipple Eval: ________________________________

□ Devices: ____________________________________

□ Other: ______________________________________

____

Interventions/ Education

□ Breast massage/ hand expression
□ Breast pumps
□ Milk production/ how to adjust supply
□ Supplementation/ proper mixing education
□ Paced bottle feeding
□ Signs of good/ poor latch
□ Proper positioning
□ Feeding cues
□ Breastfeeding/ latch aides: ______________________
□ Nutrition/ hydration
□ Herbals/ medication to discuss with doctor
□ Management of: ______________________________
□ Resources/referrals: ____________________________

Feeding Plan:

1.

2.

3.

4.

5.

Follow up: ___________ □ Phone □ In office □ Virtual

Confirm *Release of Information* has been signed by client before sending Consultation Report to HCP. Release signed? □ YES □ NO

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