Institute for Parent and Infant Care (IPIC)

Parenthood Matters!

288 Wellington Street, Stratford, Ontario N5A 2L9
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www.ipiceducation.ca

Infant Feeding/ Postnatal Consultation

PERSONAL INFORMATION: PLEASE PRINT CLEARLY

Mother/Guardian Name _____ Date of Birth (D/M/Yr) ___/___/___ Occupation _____

Father/Guardian Name _____ Date of Birth (D/M/Yr) ___/___/___ Occupation _____

Infant Name(s) _____ Date of Birth (D/M/Yr) ___/___/___ Gender □ F □ M

Siblings Names and Ages: _____

Address: _____

_____

Postal Code

Telephone _____ Home _____ Business _____ E-mail

Obstetrician/Midwife _____ Family Doctor _____ Paediatrician _____

Referred by □ Physician □ Midwife □ Family Member □ Pamphlet □ Ad in Newspaper □ Public Health Nurse □ Hospital □ Phone Book
□ Internet Search □ Friend □ Retail Outlet □ Current Client Who? _____ □ Other: Specify _____

PREGNANCY/BIRTH HISTORY:

Gravida (# of pregnancies) _____ Para (# of live births) _____ Prenatal Complications? _____

Infant's Birth Weight: _____ Infant's Current Weight: _____ Infant's Current Age: _____

Presentation at Birth: □ Vertex (Head Down) □ Posterior (Head Down/Face Up) □ Breech (Feet First) □ Transverse Lie (Side Lie)

Type of Birth: □ Vaginal □ Caesarean □ Forceps used? □ Induction How? _____ □ Epidural □ Vacuum Extraction

Duration of Labour: _____ Apgar Score (if known): _____ _____ Time After Birth of First Feeding? _____

Location of Birth: □ Hospital _____ Name of Institution □ Home □ Other _____

Complications After Birth: _____

Method of Feeding: □ Breastfeeding □ Partial Breast/ Partial Breast Milk/ Formula □ Formula □ Breast Milk Feeding with Cup/Bottle

Medical Complications of Mother/Parent: _____

Mother's Present Feelings About Parenting: □ Amazing Joy □ Tired but Happy □ Too Tired to Enjoy □ Feeling Baby Blues □ Sad
□ Not What I Expected □ Feeling A Lot of Pain □ Feeling Isolated □ Glad To Be A Parent □ Wish I Had More Support
□ So Glad For My Family □ Worried □ Feel I Have So Much To Learn □ Wish Things Were Different
□ Overwhelmed By Daily Tasks □ Feeling Numb

Father's / Guardian's Present Feelings About Parenting: □ Amazing Joy □ Tired but Happy □ Too Tired to Enjoy □ Sad
□ Not What I Expected □ Feeling A Lot of Pain □ Feeling Isolated □ Glad To Be A Parent □ Wish I Had More Support
□ So Glad For My Family □ Worried □ Feel I Have So Much To Learn □ Wish Things Were Different
□ Overwhelmed By Daily Tasks □ Feeling Numb

Mother's Medications? _____ □ Smoker? □ Alcohol Intake per day? _____

Family Ethnic Background? _____ Number of Family Members Residing in Same Household? _____

Mother's Appetite? □ Good □ Fair □ Poor Allergies? _____ Present Weight? _____

Weight Loss Desired? _____ How Soon? □ 0—2 Months □ 2 to 4 Months □ Before 6 Months □ Within 1 Year

Medical Complications of Infant? _____

Current Medications of Infant? _____

Frequency of Feeding? □ Every Hour □ Every 2 to 3 Hours □ Regular Meal Times □ Reluctant To Feed □ Feeds More At Night Than Day

Duration of Feedings? □ Less Than 10 Minutes □ 10 To 20 Minutes □ 20 To 30 Minutes □ 30 Minutes to 1 Hour □ More Than 1 Hour

Supplements Given: What? □ Formula Brand? _____ □ Colostrum/Breast Milk □ Water □ Juice □ Other _____

Why Are Supplements Given? □ Poor Urine Output □ Weight Loss □ Fussy Baby □ Medical Complications □ Returning to Work

□ Allow Another to Feed □ Breastfeeding Challenge _____ □ Mother's Feeding Preference

When Was The First Supplement Provided? _____ □ No Supplements Have Been Given

Transitional Stools (From Black Meconium to Greenish/Yellow): □ 1 To 3 Days □ 4 To 6 Days □ 7 To 10 Days +

Routine Place for Feeding? _____ Preferred Position for Feeding: □ Cradle □ Football □ Side-Lying

Present Stool Output: Colour? □ Mustard Yellow □ Black □ Greenish/Brown □ Other Foul Odour? □ Yes □ No

Consistency? □ Paste-Like □ Loose With Curds □ Watery □ Hard/Dry

Frequency? □ Every Diaper Change □ Several Per Day □ Once A Day □ Every 2 To 3 Days □ Infrequently

Urine Output: □ 8 to 12 Diapers/24 Hrs □ 6 To 8 Diapers/24 Hrs □ 3 To 6 Diaper/24 Hrs Type of Diaper Used? □ Cloth □ Disposable

Sleep Quality of Infant: □ Awake Every 2 to 3 Hours At Night □ Awake All Night □ Sleeps Most Of The Night

□ Sleeps For Long Periods Of The Night □ Poor Quality Sleep All Day and Night

□ Sleeps Better In Day Than At Night □ Good Periods Of Wakefulness And Sleep

Crying Behaviour Of Infant: □ Cries Day And Night □ Cries Only When Hungry/Wet/In Pain □ Cries More Than Expected

□ Easy To Calm When Crying □ Colicky Baby □ Cries Only At Certain Times □ High Pitched Cry

□ Never Cries - Just Fussy

What Do You Do To Calm Your Baby? _____

Reason For Visit Today? _____

Who Else Have You Sought Help From About This Issue? _____

Privacy of your personal information is an important part of our clinic. We are committed to collecting, using and disclosing your personal information responsibly. All staff members are aware of the sensitive nature of the information that you have disclosed to us and are trained in the appropriate use and protection of your information. We promise that only necessary information is collected about you and we only share your information with your consent. The Institute for Parent and Infant Care operated by IPIC Education and Counselling Services will be the health information custodian of your patient file. Our storage retention and destruction of your personal information complies with existing legislation with the College of Nurses of Ontario (CNO)

This clinic will collect, use and disclose your information for the following purposes:

- ❑ To assess your health concerns and provide health care
- ❑ To establish and maintain contact with you, or send newsletters
- ❑ To communicate with other health-care providers only with your written consent
- ❑ To allow us to efficiently follow-up for treatment, care and billing
- ❑ To invoice for goods and services and to process credit card payments

INFORMED CONSENT TO TREATMENT

This is to acknowledge and declare that I understand that:

- ❑ My care at the ***Institute for Parent and Infant Care*** will include the assessment of the whole person, taking into consideration physical, mental, emotional, spiritual and environmental factors, all of which play a role in an individuals' health. Gentle, non-invasive modalities of treatment are employed to promote wholeness and healing capacity. These modalities include, but are not limited to; assessment and intervention for lactation challenges or infant feeding and/or other concerns of parents and infants (up to the end of the first year and beyond) which may include visual and physical assessment of the mother's breasts, visual and physical assessment of the infant's mouth and/or body, observation of the mother and infant nursing, feeding and interacting, analysis of the data relating to the infant feeding/ postnatal situation, demonstration of techniques for improving infant feeding or care of the infant, and sometimes the use of medical equipment. Other modalities may include assessment, education and interventions (including supportive counselling) for prenatal, post-natal, bereavement, post partum depression, birth trauma and or any other challenge associated with pregnancy, birth and infant growth and development as well as lifestyle counselling.
- ❑ As a client of the ***Institute for Parent and Infant Care***, I hereby acknowledge that I am willing to provide the nurse consultant with the information necessary for her to fully understand my medical history, presenting symptoms, education and health goals I wish to achieve in our work together. I thereby consent to a thorough case history and relevant physical examination of myself and also my infant if applicable. In addition, if I so wish, I may consent to the presence of the father, partner or another support person during the time of the case history and exam of myself and/or our infant and/ or during the education / intervention /treatment sessions.
- ❑ Any treatment or advice provided to me as a client of Carol L. Hamilton RN, CPIC, BScN, MDiv is not mutually exclusive from any treatment or advice that I may now be receiving or may in the future receive from another licensed health care practitioner.
- ❑ I have the option to seek or continue conventional medical care from a conventional medical doctor. Carol L. Hamilton, Nurse Consultant will not suggest to me to refrain from seeking or following conventional medical treatment.
- ❑ I recognize that even the gentlest forms of treatment potentially have their risks and complications. The risks associated with nursing interventions suggested include, but are not limited to, aggravation of pre-existing symptoms, allergic reactions to supplements, creams or herbs or interactions with prescription medications.
- ❑ As with all forms of therapy, I understand that nursing intervention sought also has its limitations and thus I understand that the results are not guaranteed.
- ❑ With this knowledge, I voluntarily consent to assessment, intervention, education and care and I intend for this consent form to cover my entire course of treatment. I understand that I am free to withdraw my consent at any time.
- ❑ In the event of a medical emergency, I am advised to seek conventional medical care at a hospital.
- ❑ I agree to pay my account in full at every visit and whenever remedies/ equipment are purchased and / or rented.

By signing this form you have agreed that you have given your informed consent to treatment and to the collection, use and/or disclosure of your personal information.

Dated and signed this _____day of _____, 20_____.

Mother/ Guardian's Name _____ Signature: _____

Father/ Guardian's Name: _____ Signature: _____

Infant's Name: _____

Nurse Consultant's Signature: _____