Institute for Parent and Infant Care (IPIC)

Parenthood Matters!

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Prenatal Breastfeeding Assessment Form

PERSONAL INFORMATION: PLEASE PRINT CLEARLY

Expectant Mother's Name _____ Date of Birth (D/M/Yr) ___/___/___

Occupation _____ Family Cultural Background _____

Expectant Father's/Support Person's Name: _____ Date of Birth (D/M/Yr) ___/___/___

Occupation _____ Family Cultural Background _____

Address: _____

_____

Postal Code

Telephone _____ Home _____ Business _____ E-mail

Family Doctor/ Midwife _____ Obstetrician _____

Number of Family Members Residing in Same Household? _____ Health Concern of Either Parent? _____

Prenatal Information and History

Gravida (# of pregnancies): _____ # of Vaginal Births: _____ # of Miscarriages: _____

Para (# of live births): _____ # of Ceasarean Births: _____ # of Abortions: _____

# of Children: _____ Complications During This Pregnancy? _____

Have you ever had a sexually transmitted infection or pelvic inflammatory disease? ☐ YES ☐ NO

List any gynecologic procedures / surgeries you have had:_____

Current Health Concerns? _____

Have you noticed any breast changes during your pregnancy? ☐ Yes Describe? _____ ☐ No

Infant Feeding Method Preferred: ☐ Breastfeeding ☐ Formula Feeding ☐ Breast Milk Feeding (breast milk given via cup or bottle)
☐ Partial Breastfeeding/ Partial Formula ☐ Undecided

How did your mother feed you as an infant? ☐ Breastfeeding How long? _____ ☐ Formula ☐ Other _____

Previous Breastfeeding History (if applicable)

Did you breastfeed other children? ☐ No ☐ Yes How long? (List for each child) _____

_____

Did you desire to breastfeed but were unable to do so? ☐ Yes Why? _____ ☐ No

Did you ever feel unsuccessful with breastfeeding? ☐ Yes Why? _____ ☐ No

Did you stop breastfeeding before you wanted to? ☐ Yes Why? _____ ☐ No

Have you ever experienced any of the following? ☐ Engorgement ☐ Sore Nipples ☐ Cracked/Bleeding Nipples ☐ Breast Pain

☐ Insufficient Milk Supply ☐ Over—Abundant Milk Supply ☐ Mastitis ☐ Breast Abscess ☐ Poor Latch by Infant

☐ Breast Refusal ☐ Slow Weight Gain ☐ Colic/Fussy Infant ☐ Jaundice ☐ Other _____

How did you solve these problems? _____

_____

_____

_____

Assessment of Lactation Readiness:

Reasons for Breastfeeding? ☐ Benefits to Baby/ Mother ☐ Bonding ☐ Convenience ☐ Other (Specify) _____

Prenatal Education: ☐ Classes (With Whom?) _____ ☐ Reading ☐ DVD/ TV ☐ Witnessed birth of friend/family member

On a scale of 1 (least supportive) to 5 (most supportive):

How supportive with breastfeeding would you rate your partner/support person? _____

How involved will your partner/support person be in the day to day care of your infant? _____

Do you desire pain medication during your labour? ☐ Yes (Specify what, if known) _____ ☐ No

How soon after birth do you hope to breastfeed? ☐ Immediately ☐ Within the first hour ☐ 1 to 3 hours after ☐ When I feel like it

Do you wish to supplement your infant's feedings? ☐ No ☐ Yes (With Breastmilk? ___ Formula? ____) ☐ Undecided

How soon do you hope to introduce a bottle nipple to your infant? ☐ Never ☐ After 6 weeks ☐ When needed ☐ When returning to work

What family member/ friend will be your greatest support with breastfeeding? _____

Have you ever watched a mother breastfeed? ☐ No ☐ Yes How did you feel about this experience? _____

_____

Indicate which of the following people you have already consulted about your breastfeeding experience:

☐ Family Member ☐ Friend Who Has Breastfed ☐ Hospital Breastfeeding Clinic ☐ Community Health Nurse

☐ Family Doctor ☐ Nurse— Family Practice Team ☐ Midwife ☐ Doula ☐ Chiropractor ☐ Massage Therapist

☐ Community Breastfeeding Support Group ☐ Nurse Practitioner ☐ Naturopathic Doctor ☐ Other _____

Social History

Are you? ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Significant Other

Highest level of education: ☐ College/University ☐ High School ☐ Other_____

Do you smoke? ☐ YES If yes ☐ Less than I Pack /Day ☐ More than 1 Pack /Day ☐ Other_____ ☐ No, I don't smoke

How long have you smoked?_____ Do you drink? ☐ YES ☐ NO If yes # of drinks per day_____

Do you get regular exercise? ☐ YES ☐ NO If yes, how often?_____

Do you have any dietary restrictions? ☐ YES ☐ NO _____

Do you feel safe at home? ☐ YES ☐ NO Do you want to discuss abuse? ☐ YES ☐ NO

Are any of your immediate family members suffering a significant medical condition?

_____

_____

Current Medications? _____

_____

Referred By: ☐ Physician ☐ Midwife ☐ Family Member ☐ Pamphlet ☐ Ad in Newspaper ☐ Community Health Nurse ☐ Hospital

☐ Phone Book ☐ Internet Search ☐ Friend ☐ Retail Outlet ☐ Current Client Who? _____

□ Naturopathic Doctor □ Chiropractor □ Community Organization ☐ Other: Specify _____

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 readiness, which may include visual and physical assessment of the mother's breasts, demonstration of techniques for improving breastfeeding success, and sometimes the use of medical equipment. Other modalities may include assessment and interventions (including supportive counselling) for prenatal, postnatal, bereavement, or any other challenge associated with pregnancy and 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, educational 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. In addition, if I so wish, I may consent to the presence of another support person in the case history and exam of myself and/or during the intervention and education session.
- ❑ 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 and care (including education/ supportive counselling) 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.

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

Dated and signed this _____day of _____, 20_____.

Expectant Mother's Name _____ Signature: _____

Expectant Father's/Support Person's Name: _____ Signature: _____

Nurse Consultant's Signature: _____