

Lactation Consultation

Intake Form

Please complete this form and email to: info@pccfht.ca. Please call Family Health Team Reception at 519-442-9834 to book.

Please complete all fields and select all applicable consultation needs.

Child and Parent Information

Child's Name

Date of Birth (YYYY-MM-DD)

Child's Health Card Number and Version Code

Birth Weight (include units - lbs./kg)

Parent(s) Name(s)

Address (including postal code)

Phone Number

Email Address

Health Care Providers and Feeding

OB/GYN, Midwife, Pediatrician, Family Physician or NP (Please include full name of Healthcare Professional(s) and location(s) if available)

Current Feeding (breastfeeding, partially breastfeeding and/or supplementing)

What are your feeding goals for your child(ren)?

Lactation Consultation

Consultation Needs and Consent

Child's Name (to identify this page)

Consultation Needs

Select all that apply. Appointment lengths are shown in parentheses.

- ☐ Assistance with latch and positioning on the breast (60 min)
- ☐ Advice on pacifiers or bottles (30 min)
- ☐ Assistance with breast pump (60 min)
- ☐ Weaning or introduction of solids (60 min)
- ☐ Introducing a bottle to a breastfed baby (30 min)
- ☐ Milk supply or milk letdown issue (60 min)
- ☐ Breast concern (e.g., mastitis or clogged duct / 30 min)
- ☐ Tongue tie assessment (30 min)
- ☐ Other (please specify in the field below)

Primary Reason for Assessment / Other Consultation Need

Consent and Acknowledgment

Consultations are provided by Registered Nurses who are International Board Certified Lactation Consultants (IBCLCs).

I agree to participate in lactation consultation. The nurse will explain the proposed assessment and care, including expected benefits, relevant risks and alternatives, answer my questions, and obtain informed consent before proceeding, including before any examination or hands-on assistance. I may decline any part of the consultation or stop services at any time.

The PrimaCare Registered Nurse/IBCLC may request and share relevant information about my and/or my child's care with the health care provider(s) listed on page 1 as necessary to coordinate care for lactation and feeding or other external provider(s) for referral purposes discussed during the lactation consultation.

If "no" is checked, personal health information will only be shared if required by law.

☐ Yes ☐ No

Limits on Sharing / Provider(s) Excluded (if Any)

Signature (sign or type name)

Date (YYYY-MM-DD)

Name and Relationship / Authority if Signing for the Child or Another Person