

SAMPLE

**INTAKE FORM AND GENERAL CONSENT FOR
INTERNATIONAL BOARD CERTIFIED LACTATION CONSULTANT SERVICES**

| | | | | | |
|------------------|------------|-----|---------------|----------------|-----|
| Baby's Last Name | First Name | Age | Date of Birth | Weeks Pregnant | Sex |
|------------------|------------|-----|---------------|----------------|-----|

| | | |
|---------------------|---------------------|---------------------|
| _____ lb. _____ oz. | _____ lb. _____ oz. | _____ lb. _____ oz. |
| Baby's Birth Weight | Discharge Weight | Current Weight |

| | | | | |
|--------------------|------------|-----|---------------|------------|
| Mother's Last Name | First Name | Age | Date of Birth | Occupation |
|--------------------|------------|-----|---------------|------------|

| | | | | |
|--------------------|------------|-----|---------------|------------|
| Father's Last Name | First Name | Age | Date of Birth | Occupation |
|--------------------|------------|-----|---------------|------------|

Mother's Home:

| | | | |
|----------------|------|-------|-----|
| Street Address | City | State | Zip |
|----------------|------|-------|-----|

| | | |
|------------------|-----|----------------|
| Telephone Number | Fax | E-mail Address |
|------------------|-----|----------------|

Mother's Work:

| | | | |
|----------------|------|-------|-----|
| Street Address | City | State | Zip |
|----------------|------|-------|-----|

| | | |
|------------------|-----|----------------|
| Telephone Number | Fax | E-mail Address |
|------------------|-----|----------------|

Father's Home:

| | | | |
|----------------|------|-------|-----|
| Street Address | City | State | Zip |
|----------------|------|-------|-----|

| | | |
|------------------|-----|----------------|
| Telephone Number | Fax | E-mail Address |
|------------------|-----|----------------|

Father's Work:

| | | | |
|----------------|------|-------|-----|
| Street Address | City | State | Zip |
|----------------|------|-------|-----|

| | | |
|------------------|-----|----------------|
| Telephone Number | Fax | E-mail Address |
|------------------|-----|----------------|

Pediatrician:

| | | | | |
|------|----------------|---------|-------|-----|
| Name | Street Address | Suite # | | |
| City | State | Zip | Phone | Fax |

OB/GYN, MD, DO, CNM:

| | | | |
|------|----------------|---------|-------|
| Name | Street Address | Suite # | |
| City | State | Zip | Phone |

Referred By:

| | | | |
|----------------|------|-------|-----|
| Name | | | |
| Street Address | City | State | Zip |

Why have you requested this consultation?

I grant permission to [NAME OF IBCLC OR AGENCY] to share pertinent information about this consultation with my/our family physicians and health care providers, the referring person, my/our community breastfeeding helper, my/our insurance companies and to further the knowledge of breastfeeding. I/We understand that all medical care is to be provided by my/our own physician(s). I also give my consent to [NAME OF IBCLC OR AGENCY] to observe me breastfeeding and/or to examine my breasts during the period of lactation assistance.

Date

Signature of Mother or Father

Date

Signature of IBCLC