Dear New Patient,

Welcome to Whole Health Naturopathy for your Initial Lactation Consultation with Carrie DiStefano, IBCLC. This letter outlines the benefits of lactation services at Whole Health Naturopathy, what to bring to the appointment and, on the second page, how to inquire about your insurance benefits specific to this visit.

Benefits of scheduling at Whole Health Naturopathy:

- One-to-one, personal and in-depth interaction with lactation expert
- Payment for the visit at time of service is not required and insurance is billed on your behalf
- All visits are overseen by a physician. The physician is available to step in if additional evaluation and management are required (i.e. prescription)

Please bring the following to each lactation visit:

- Mom and baby!
    - Please do not breastfeed or pump immediately before visit. Last feed is recommended to be no more than an hour before appointment time. We want to observe a feeding under normal conditions and need to assess milk supply and milk intake. Example: if appointment is at 1:30pm last feeding should be no later than 12:30. We know this is not always easy, but do your best!
- Nipple shields if you use them. Please bring all sizes you have as sometimes mothers may be using an incorrect size.
- A clean breast pump and all pump parts (if pumping is a part of your routine) so that we can check its fit
- Expressed breast milk and/or formula, and preferred device for feeding baby, if you are using either of these to supplement
- A (recent) weight history for your baby and medications/supplements that you or baby may be taking
- We welcome partners, grandparents, siblings, or helpers – as long as they are all healthy!

Please see the next page for instructions on checking insurance benefits.

Insurance coverage:

- All visits are billed under the overseeing naturopathic physician's license, and visits are billed separately for mom and baby
- Lactation visits are billed under Nutrition or Counseling codes. **Please call your insurance before your visit to verify if you have these benefits:**
    1. Ask if you have coverage to see naturopathic doctor
    2. For mom's portion of the visit, ask if you have Preventative Counseling benefits, CPT code 99404
    3. For infant's portion of the visit, ask if he or she has Nutrition benefits, CPT code 97802 (initial) and 97803 (follow up)
    4. Inquire if your plan has benefit limits for counseling and nutrition
- Insurance has not yet developed lactation codes that apply to the outpatient clinical setting (outside of a hospital or home visit setting), so inquiring about "Lactation Benefits" may be misleading
- Insurance coverage for your visits may be applied to your deductible and there may be an applicable co-pay or co-insurance.
- You will be financially responsible for the amount determined by your insurance coverage. Whole Health Naturopathy mails out patient invoices monthly.

Thank you for taking the time to read through this and better understand insurance and lactation benefits.

Please contact us if any further clarification is needed. We look forward to meeting you and helping you meet your breastfeeding goals!

Sincerely,

Whole Health Naturopathy

LACTATION CONSULTATION

INTAKE AND CONSENT FORM

MOTHER

Your Name _____ Your Birth Date ___/___/___ Your Age _____ Your Profession _____

Street Address _____ City _____ State _____ Zip _____

Partner's Name _____ Partner's Profession _____ Best phone to reach you: ❑ Home/Landline ❑ Cell

Phone (home/landline) _____ Phone (cell) Do you text? ❑ Yes ❑ No _____ Email _____

Note that text and email messages are not secure and cannot protect your private health information (PHI)

How would you prefer to receive the report from this consult? ❑ Email ❑ Regular Mail ❑ Faxed To: _____

Referred by: ❑ Friend/Family:_____ ❑ Hospital:_____ ❑ Doctor: _____

Website: ❑ _____ ❑ Internet search ❑ Other referral source: _____

BABY

Baby's Full Name _____ Sex: ❑ M ❑ F Due Date ___/___/___ Birth Date ___/___/___ Weeks Gestation at Birth _____

Place of Birth _____ City/State of Birth _____

INSURANCE

Insurance Company _____ Primary Insured's Name _____

Primary Insured's Employer _____ Date of Birth ___/___/___ ❑ Self ❑ Spouse ❑ Other Relationship to Mother

Member Number:_____ Group Number: _____

HEALTH CARE PROVIDERS

OBSTETRICIAN / MIDWIFE	PEDIATRICIAN
Name _____ Send report? ❑ No ❑ Yes (provide following info):	Name _____
City and State _____	City and State _____
Phone _____	Phone _____ Fax _____

I understand that:

- All medical care is to be provided by my own physician(s) and that any change from his/her/their recommendations should be discussed with him/her/them.
- A lactation consultation by the IBCLC may include a visual and manual assessment of the mother's breasts, the baby's mouth and suck, observation of the mother and baby breastfeeding, analysis of information relating to the breastfeeding situation, demonstration of techniques for improving breastfeeding, use of breastfeeding equipment, and recommendation of a care plan to resolve breastfeeding issues, which may be adjusted during the course of treatment.
- A student intern may accompany the IBCLC and participate in the consultation for training purposes.
- I am responsible for informing the lactation consultant(s) of any relevant information or changes that affect my breastfeeding situation.
- *It is my responsibility to call the lactation consultant(s) with progress reports, questions, or concerns.*
- This practice will submit a claim for direct payment of insurance benefits with participating insurance company and bill me for any remaining co-pay or fees. For those who are not insured or who are insured with a company with which we do not participate, payment for services and supplies are my sole responsibility and required at the time of service; a receipt will be provided for insurance reimbursement.

I grant consent for:

- Information about this consultation to be mailed, faxed, or emailed to my attending physician/health care providers.
- The release of any medical information necessary to process any insurance claim(s) and payment of any insurance benefits directly to this practice.
- Information from this consultation to be used for teaching purposes, with the understanding that no names or identifying features will be used.
- Treatment according to the scope of practice outlined above.

My signature below acknowledges my understanding of the conditions set forth above.

_____ _____

Client Signature **Date**

_____ **INITIALS** I give permission for photos and/or videos of my lactation visit to be taken and used solely for educational purposes, including presentations at professional conferences and workshops without further notice or compensation. No identifying information will be present in any photograph or video.

INTAKE HISTORY

PAGE ONE

Mother's Name _____

Consultation Date _____

Problem: ❑ nipple pain ❑ latch ❑ breast refusal ❑ undersupply ❑ oversupply ❑ slow weight gain ❑ multiples ❑ other_____

Others consulted about this breastfeeding issue: ❑ LC ❑ doctor ❑ nurse ❑ LLL ❑ friend ❑ family ❑ doula ❑ other _____

Ultimate breastfeeding goal: ❑ breastfeed exclusively ❑ pump exclusively ❑ bf and pump ❑ bf and supplement ❑ unsure ❑ whatever happens

YOUR HEALTH HISTORY

Any history of: ❑ thyroid ❑ ovarian cyst ❑ Polycystic Ovarian Syndrome (PCOS) ❑ diabetes (type ❑ I ❑ II) ❑ other: _____

_____

Medications currently taking (including herbs and vitamins): _____

Breast or chest surgery or injury: ❑ none ❑ reduction ❑ mastopexy ❑ augmentation ❑ biopsy ❑ injury ❑ other **Date:**_____

Conceive easily: ❑yes ❑ no (how long: _____) ❑ IVF ❑ IUI (donated: ❑ sperm ❑ egg ❑ neither)

Abortion(s): ❑ no ❑ yes (#_____ year(s) _____) **Miscarriage(s)**: ❑ no ❑ yes (#_____year(s) _____)

Miscarriage(s) reason(s): ❑ unknown ❑ _____

Number of other pregnancies: _____ **Number of other children living:** _____

BREASTFEEDING HISTORY

Number of other children breastfed: _____ **How long other child(ren) breastfed: #1:** ____ ❑ wks ❑ mos ❑ yrs

#2: ____ ❑ wks ❑ mos ❑ yrs | **#3:** ____ ❑ wks ❑ mos ❑ yrs | **#4:** ____ ❑ wks ❑ mos ❑ yrs | **#5:** ____ ❑ wks ❑ mos ❑ yrs

How did breastfeeding go with the older child(ren): ❑ easy ❑ difficult (describe): _____

_____

_____

THIS PREGNANCY

Breast changes: ❑ enlargement ❑ tenderness in first trimester ❑ leaking ❑ areola darkening **Any complications:** ❑ no ❑ yes: _____

_____

Bed Rest: ❑ no ❑ yes (start week: _____ until week_____**)** **Reason:** _____ **Pregnancy length:** _____ wks _____ day(s)

LABOR

How labor began: ❑ spontaneous ❑ induced (how: ❑ pitocin ❑ cervical gel ❑ membrane ruptured ❑ other:_____)

Where: ❑ home ❑ birth ctr ❑ hospital ❑ other **Labor:** ___ hrs **Pushing:** ____ min **Delivery:** ❑ vag (❑ VBAC) ❑ vacuum ❑ forceps ❑ C-sect

Medications during labor: ❑ pitocin ❑ epidural (#cm when started: _____) ❑ narcotic (demerol, nubain) ❑ other _____

Antibiotics: ❑ no ❑ yes (reason: ❑ strep B ❑ fever ❑ C-sect ❑ other _____) **Hemorrhage:** ❑ no ❑ yes (med to stop: _____)

LABOR EXPERIENCE: _____

_____

_____

HOSPITAL / POSTPARTUM

1st nursing: ____ min /hrs after birth ❑ easy ❑ difficult **Sides:** ❑ 1 ❑ 2 **When milk came in:** day ____ ❑ not noticed ❑ slight ❑ mod ❑ heavy

1st 24 hours frequency: every_____ hours **2nd 24 hours frequency:** every_____ hours **3rd 24 hours frequency:** every_____ hours

❑ **Circumcision** (Day _____) **Pacifier:** ❑ no ❑ yes (when began: day_____) **Separation:** ❑ none ❑ some ❑ night ❑ mostly nursery ❑ NICU

Baby complications: ❑ jaundice ❑ hypoglycemia ❑ other _____ **How treated:** _____

INPATIENT BREASTFEEDING EXPERIENCE: _____

_____

_____

_____

_____

INTAKE HISTORY

PAGE TWO

AT HOME

FEEDINGS: **How often**: ____ min/hrs **LATCHING**: ❑ easy ❑difficult ❑ impossible **Who ends:** ❑ me ❑ baby **Avg length:** ____ min

Nipple pain: ❑ none ❑ some ❑ moderate ❑ severe **Which nipple(s)**: ❑ L ❑ R **When began**: _____ ❑ days ❑ weeks ❑ months

SUPPLEMENTING: ❑ no ❑ yes **When began**: ____ days **How:** ❑ bottle ❑ cup ❑ syringe ❑ dropper ❑ spoon ❑ finger-feeder ❑ tube

When: ❑ before nursing ❑ after **How often:** ❑ every feed ❑ _____ x/day **How much:** ____oz/cc /feeding **What:** ❑ formula ❑ pumped milk

PUMPING: ❑ no ❑ yes **When began**: ____ days **How often:** _____ x/day **Avg amt:** _____ **Flange size** (imprinted on side): _____

Pump condition: ❑ new ❑ used (how long: _____ mths/yrs) **Pump Type**: ❑ rental ❑ owned (brand: _____)

POST-DISCHARGE BREASTFEEDING EXPERIENCE:_____

_____

_____

_____

_____

_____

_____

_____

Vaginal bleeding now: ❑ light ❑ moderate ❑ heavy ❑ over **Color:** ❑ bright red ❑ dark red ❑ brown

WHERE BABY SLEEPS: ❑ in our room ❑ in her/his room ❑ other:_____ **What baby sleeps in**: ❑ our bed ❑ co-sleeper ❑ crib/bassinet

NUMBERS

BABY'S WEIGHT HISTORY

DATE	WHERE WEIGHED	WEIGHT
BIRTH		

DIAPER OUTPUT HISTORY

DAY	Last 24 Hours	Last 25-48 Hours	Last 49-72 Hours	Last 73-96 Hours	Last 97-120 Hours
No. of Stools					
Stool Qty	❑ More than a spoonful	❑ More than a spoonful	❑ More than a spoonful	❑ More than a spoonful	❑ More than a spoonful
Stool Color	❑ Black ❑ Brown ❑ Green ❑ Yellow	❑ Black ❑ Brown ❑ Green ❑ Yellow	❑ Black ❑ Brown ❑ Green ❑ Yellow	❑ Black ❑ Brown ❑ Green ❑ Yellow	❑ Black ❑ Brown ❑ Green ❑ Yellow

Attend breastfeeding mothers' group: ❑ no ❑ yes (Where: _____)

Ideally, want to breastfeed: _____ ❑ months ❑ years ❑ until baby weans self **Returning to work (outside home):** ❑ no ❑ yes (At _____ ❑ wks ❑ mos)