Client Consent to Lactation Consultation by

Christy Jo Hendricks, IBCLC, RLC, CLE, CCCE, Doula

Consultation date ________________________

Mother's/Birthing Parent's Name___________________________ Partner's Name ___________________________

Baby's Name_________________________ Birthdate ________________________________

- I understand that all medical care is to be provided by my own physicians and that any change from a physician's recommendations should be discussed with the physician.
- I grant permission for information about this consultation to be sent to my attending physician/health care providers if necessary.
- I grant permission for information about this consultation to be discussed with my partner (if named above), unless I specify otherwise.
- I grant permission for information from this consultation to be used to further the knowledge of breastfeeding, with the understanding that no names or identifying features will be used.
- I understand that a lactation consultation by the International Board Certified Lactation Consultant (IBCLC) may include a visual and physical 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 treatment plan to resolve breastfeeding issues, which may be adjusted during the course of treatment.

I hereby give consent for treatment according to the scope of practice outlined above.

- I understand that the well-being of the parent and baby are of utmost importance and resolving breastfeeding issues may involve recommending supplementation to ensure adequate milk transfer.
- I understand that the consultation will provide suggestions, resources, references, and protocols. I understand that I am responsible for informing the lactation consultant of any relevant information or changes that affect my breastfeeding situation and update on any progress or regressions I observe.
- I understand that evidence-based information and advice will be shared, but there are no guarantees that all issues can or will be resolved by the lactation consultant.
- I understand that it is my responsibility to call the lactation consultant with progress reports, questions, or concerns.
- I understand that payment for lactation consultation services and any necessary breastfeeding equipment are my sole responsibility and expected at the time of service. There are no refunds provided for consultations.

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Name (Please Print)

__________________________________ ________________
Signature Date

Christy Jo Hendricks, IBCLC, RLC, CLE, CCCE, Doula
Birthingandbreastfeeding.com
951.809.7827