WNY LATCH LAB

Section A – Demographics

Race / Ethnicity (check all that apply):

☐ Black or African American ☐ White ☐ Hispanic / Latine ☐ Asian

☐ American Indian / Alaska Native ☐ Middle Eastern / North African ☐ Other: _____

Primary Language: _____Interpreter Needed:

☐ Yes ☐ No If Yes, specify language: _____

If you would like WNY Latch Lab to share information with your healthcare providers, please list below and sign consent in Section
OB Provider: _____

Pediatrician: _____

Section 1 – Parent / Guardian Information

Name: _____ Date of Birth: _____

Address: _____ZIP:_____

Phone: _____ Email: _____

Insurance Provider: _____ Policy #: _____

Breast / Chest Surgery or Procedures: ☐ Yes ☐ No → Details:
_____

Current Medications or Supplements:
_____

Section 2 – Infant Information

Infant's Full Name: _____

Date of Birth: _____ Gestational Age at Birth: ____ weeks

Sex: ☐ Male ☐ Female ☐ Other/Prefer not to say

Birth Weight: _____ (lbs/oz)

2-Week Weight: _____ (lbs/oz) Date: _____

Current Weight: _____ (lbs/oz) Date: _____

Delivery Type: ☐ Vaginal ☐ Cesarean ☐ VBAC Birth

Facility / Hospital: _____

NICU Stay: ☐ Yes ☐ No

Vitamin D Supplementation: ☐ Yes ☐ No

Tongue/Lip Tie: ☐ Yes ☐ No → If released, date: _____

Section 3 – Feeding Information

(check all that apply and fill blanks)
☐ Breastfeeding at breast ☐ Pumping and bottle-feeding
☐ Formula ☐ Combo feeding
☐ Supplemental Nursing System ☐ Cup or syringe feeding
☐ Exclusive pumping

Times breastfed in last 24h: ___

Duration (avg minutes per feed): ___

Baby content/sleep between feeds: ☐ Yes ☐ No

Bottles in last 24h: ___ Longest day interval (hrs): ___
Night interval (hrs): ___

Wet diapers (24h): ___ Soiled diapers (24h): ___

Pump type/brand: _____ Output per session: ____oz

Breast pump flange size:____mm Pumping Discomfort _____

Section 4 – Pregnancy, Birth, and Hospital Experience

☐ Epidural ☐ Induction ☐ Excessive blood loss (>500 mL)
☐ Infection during labor ☐ Separation after birth
☐ Baby required phototherapy ☐ Breastfeeding within 1 hour of birth

Section 5 – Nursing Aids Used

☐ Nipple shield ☐ Breast shell ☐ Supplemental Nursing System
☐ Cup feeding ☐ Syringe feeding ☐ Pump ☐ Haakaa
☐ Hand expression ☐ Other: _____

Section 6 – Maternal Health & Lactation Factors

☐ Thyroid disorder ☐ PCOS ☐ Diabetes ☐ Anemia
☐ Low supply history ☐ Breast surgery ☐ Breast asymmetry
☐ Pain / engorgement ☐ Nipple trauma
☐ Depression / anxiety ☐ Current medications
☐ Other: _____

Section 7 – Consent to Lactation Care

I understand that lactation consultants at WNY Latch Lab provide evidence-based lactation assessment, education,

and support. I consent to an examination of the breasts/chest, observation of feeding, and oral assessment of my infant as part of the care process.

I understand that IBCLCs do not diagnose or prescribe medication. I agree to contact my healthcare provider for medical concerns.

I authorize WNY Latch Lab to communicate with my healthcare providers as needed for coordinated care. If I listed my OB and/or pediatrician in Section A, I consent to sharing relevant lactation information with those providers.

I consent to follow-up contact by text, phone, or email, and understand telehealth visits may be used when appropriate.

Section 8 – Signatures

Parent/Guardian Name: _____
Signature: _____ Date: _____

Consultant Name: _____
Signature: _____ Date: _____

Phone/Text **585-888-1063**
Email wnylatchlab@gmail.com
Facebook @WNYLatchLab