

Breastfeeding Peer Counselor Hospital Participant Contact

Mother's Information

Name: _____ Age: _____

Address: _____

Phone Number(s) _____ WIC ID# _____

Maternal History and Previous Breastfeeding Experience

Previous Breastfeeding experience:	Sore Nipples:
Positioning: correct/needs assist	Health problems/meds?

Baby's Information

DOB: _____ Weeks Gestation: _____ Sex: M F

Baby's Name: _____

Birth weight: _____ pounds _____ grams Birth length: _____

Pediatrician: _____

Latch on: good/needs help	How often does baby nurse?
How long do feedings last?	Health problems/meds?

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Attending OB/GYN Doctor:

Information Given:

Topics discussed at visit:

_____ Normal nursing patterns, including frequency and duration of each feeding (*nurse often, no limits of frequency, cluster feedings, growth spurts*)

_____ Engorgement

_____ Normal maternal feelings when breastfeeding (*drowsiness, uterine contractions, thirst*)

_____ Baby's bowel movements and wet diaper count

_____ Baby's weight loss / gain

_____ Tips for waking a sleepy baby

_____ Proper positioning

_____ How to break baby's suck

_____ Baby's stomach capacity (Day 1= 5-7ml, Day 3= 22-27ml, Day 10 = 45-60ml)
30ml = 1oz

_____ Pumping Tips

_____ Importance of mother-baby togetherness; skin to skin contact

_____ AAP recommends breastfeeding for all infants unless medical reasons contraindicate breastfeeding (HIV, galactosemia, etc.); See **Policy 5.24 Breastfeeding Contraindications**

_____ Pacify App

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