International Board Certified Lactation Consultant – Registered Lactation Consultant
www.HarrisburgBreastfeeding.com 717-712-6822
EIN # 20-1989784

Mother's name: ______________________________ DOB: ______________

Address: ______________________ City: __________________ Zip: __________

Phone: home ___________________________ cell ___________________________

Email: ___________________________ Referred By: __________________

OB/Midwife: ______________________ Phone: ________________ Fax: ______________

Address: ____

Baby's name: ____________________ Age: ______ DOB: ________ Sex: _________

Pediatrician: ______________________ Phone: _________________ Fax: _____________

Address: ____

Release and Consent

A lactation consultation usually includes visual and physical assessment of the mother's breasts, visual and physical assessment of the infant's mouth, observation of the mother and infant nursing, analysis of the data relating to the breastfeeding situation, demonstration of techniques for improving breastfeeding, and sometimes the use of breastfeeding equipment. I give permission for the lactation consultant to do all of the above.

I understand that I will be charged a fee for this consult and that payment is due at the time services are rendered. I give my permission for information to be released to my insurance company to assist in evaluation of a claim.

I understand that all medical care is to be provided only by my own physician and/or health care providers. I grant permission to Shannon Lilienthal to share pertinent information about this consultation with my obstetrician and pediatrician to assist in medical treatment for my baby and/or myself. I understand that I have the right to refuse any or all specific techniques suggested, equipment to assist or remedy breastfeeding problems, and/or all recommended actions.

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Mother's Signature Date

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Lactation Consultant's Signature Date