BREASTFEEDING: ASSESSMENT AND DISCHARGE

Part A: FIRST BREASTFEEDING EXPERIENCE

Initial when complete

INFANT	MOTHER
Relevant Information and Risk Factors (mom or baby):	**Breast/Nipple Assessment Completed** ☐ Prenatally ☐ After birth Comments:
Initial Skin-to-Skin: __ Immediate __ Delayed Length of Delay:_____ __ None If delayed or none, identify medical reason: ☐ Skin-to-skin until at least end of first feed; if discontinued prior to this explain: Initial Breast Contact: ☐ N or ☐ Y Date/Time:_____ First Breastmilk (Colostrum) Transfer: Date/Time:_____ ☐ At breast ☐ Drops given ☐ No breastmilk transfer (explain): ☐ Skin-to-skin during transfer between care areas	Mother's Breastfeeding Goals* Mother's Breastfeeding Concerns: **Maternal Response to First Breastfeeding Experience**: ☐ Physically Comfortable Maternal concerns: ☐ Emotionally Comfortable ☐ Not Comfortable Low High Self-efficacy/confidence –(circle): 1 2 3 4 5 ☐ Assistance required and given (explain) **Post Feed Nipple Assessment** ☐ Same as prefeeding ☐ Misshapen ☐ Painful ☐ Damaged Describe:

Part B: EDUCATION (* = required topics for BFI)

Initial		Initial	
	☐ * Importance of exclusive breastfeeding		☐ Milk transfer
	☐ * Breastfeeding recommendations		☐ Signs of adequate intake
	☐ * Importance of skin-to-skin		☐ Hunger & satiation cues
	☐ * Hand expression		☐ Normal newborn weight loss
	☐ * Infant states & effect on breastfeeding		☐ Breast & nipple care
	☐ * Soothing babies without use of pacifiers		☐ Milk production
	☐ * Importance of mother-baby togetherness, especially at night and including sleep strategies		☐ Growth spurts
	☐ * Safe Sleep		☐ Engorgement prevention
	☐ * Positioning & latching		☐ * Expressed breastmilk storage, handling & feeding
	☐ * Frequency of feedings		☐ * Family planning
	☐ * Clusterfeeding		☐ * Professional & peer community breastfeeding supports
	☐ * Increasing volumes		☐ * Rights of breastfeeding mothers
	☐ * Informed decision-making		☐ Other:

Part C: REFERRALS

Initials:

Please list:

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Part D: BREASTFEEDING FOLLOW UP (date if appointment arranged and initial)

☐ Physician/Midwife/NP _____	Date/Time Appt _____	Initial _____
☐ Public Health _____	Date/Time Appt _____	Initial _____
☐ Out-patient Clinic (return to unit) _____	Date/Time Appt _____	Initial _____
☐ Peer Support _____	Date/Time Appt _____	Initial _____
☐ Lactation consultant _____	Date/Time Appt _____	Initial _____
☐ Other _____	Date/Time Appt _____	Initial _____

Part E: FEEDING DISCHARGE SUMMARY

Initials:

Discharge Date & Time _____

Infant Age (days & hours) _____

Weight @ 24h _____ Discharge weight _____

Weight loss ≥ 10%? N Y If yes, % lost : _____

voids last 24 hours _____

stool & type last 24 hours _____

☐ Waking independently for feedings

☐ Requiring waking for feedings

Describe _____

_____

☐ Breastfeeding exclusively ☐ EBM

☐ Breastmilk substitute (e.g. formula)

Method of supplement _____

Medical Indication _____

☐ Not currently breastfeeding _____

Comments _____

Maternal Assessment

☐ Physically comfortable

☐ Emotionally comfortable

☐ Not comfortable

☐ Self-efficacy/confidence (low to high) 1 2 3 4 5

Maternal Concerns:

Current Breastfeeding Goals:

Discharge Feeding Plan (please attach additional sheet if required)

Continue with:

Work toward:

Seek professional assistance if:

PRINT NAME	SIGNATURE/STATUS	INITIALS