Mother's Name: _____ Health Care Provider: **LOIS DEL SETTE, R.N. I.B.C.L.C.**

Baby's Name: _____ **518-505-7835** **Certified Lactation Consultant**

Date of Birth: _____ Hospital # _____

DATE:

Time of Day	Minutes of Time each Breast		Can you Hear Swallowing?	No. Wet Diapers	No. Stools & color	Suplement Amt. of water/formula	Amount Pumping Breastmilk	Other
1st.	Lft.	Rt.	Yes__ No__	#	#		oz.	
2nd.	Lft.	Rt.	Yes__ No__	#	#		oz.	
3rd.	Lft.	Rt.	Yes__ No__	#	#		oz.	
4th.	Lft.	Rt.	Yes__ No__	#	#		oz.	
5th.	Lft.	Rt.	Yes__ No__	#	#		oz.	
6th.	Lft.	Rt.	Yes__ No__	#	#		oz.	
7th.	Lft.	Rt.	Yes__ No__	#	#		oz.	
8th.	Lft.	Rt.	Yes__ No__	#	#		oz.	
9th.	Lft.	Rt.	Yes__ No__	#	#		oz.	
10th.	Lft.	Rt.	Yes__ No__	#	#		oz.	
Totals	# of breastfeeding sessions _____			#	#			
Normal Range within 24 Hours	8-10		Yes	6-9	2-5			

DATE:

Time of Day	Minutes of Time each Breast		Can you Hear Swallowing?	No. Wet Diapers	No. Stools & color	Suplement Amt. of water/formula	Amount Pumping Breastmilk	Other
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2nd.	Lft.	Rt.	Yes__ No__	#	#		oz.	
3rd.	Lft.	Rt.	Yes__ No__	#	#		oz.	
4th.	Lft.	Rt.	Yes__ No__	#	#		oz.	
5th.	Lft.	Rt.	Yes__ No__	#	#		oz.	
6th.	Lft.	Rt.	Yes__ No__	#	#		oz.	
7th.	Lft.	Rt.	Yes__ No__	#	#		oz.	
8th.	Lft.	Rt.	Yes__ No__	#	#		oz.	
9th.	Lft.	Rt.	Yes__ No__	#	#		oz.	
10th.	Lft.	Rt.	Yes__ No__	#	#		oz.	
Totals	# of breastfeeding sessions _____			#	#			
Normal Range within 24 Hours	8-10		Yes	6-9	2-5			