

Mid Certification - Exclusively/Mostly BF Woman

CPA Signature: _____

Date: _____

Reason Not Present: ☐ Medical Equipment Not Transportable ☐ Confined to Bed ☐ Serious Illness ☐ Transfer Out of State

Breastfeeding Status (Document if BF status has changed)

Are you currently BF or pumping? ☐ No ☐ Yes **Are you currently giving any supplemental formula?** ☐ No ☐ Yes

Amount of BF: ☐ Mostly ☐ Some **Did you ever BF or feed your baby breast milk?** ☐ No ☐ Yes ☐ Unknown

Date Supplemental feeding began: _____ **Date BF ended:** _____ **Reason:** _____

Did you BF as long as you desired? ☐ No ☐ Yes **Category:** ☐ BE ☐ BP ☐ NPP

BF Information

How is BF going? _____

How many times is the baby BF or given breast milk in a day (24 hours)? _____

Are there any concerns about BF? _____

BF Referral to:

- ☐ WIC
- ☐ Community Support
- ☐ No Referral Made

Reason Referred:

- ☐ Nipple Issues
- ☐ Breast Surgery
- ☐ 1st Time Pregnant
- ☐ General Support
- ☐ Expecting Multiples
- ☐ Needs Support/Unsure
- ☐ Medical Condition

Reason Not Referred:

- ☐ Baby Being Placed for Adoption
- ☐ CPA Professional Judgement
- ☐ Client Declined
- ☐ No Local Referral Resource Available

Lab Data

Current Ht: _____ **in** _____ **1/8** **Current Wt:** _____ **lbs** _____ **oz** _____ **HGB** _____

No Blood: ☐ **Exemption Reason:** ☐ CPA Determined Blood work skip ☐ Delayed Blood Work
☐ Medical Condition Prevents Safe Collection ☐ Religious Belief

Mid Certification

Has your health changed in the last few months? _____

What questions do you have about weight gain or weight loss? _____

Tell me about the types of physical activity you do: _____

What are some healthy nutrition habits you practice? _____

How is your appetite? _____

Nutrition Risk (* = High Risk)

Medical Conditions

- | | | |
|---|---|--|
| <input type="checkbox"/> 303 Hx of Gest. Diabetes | <input type="checkbox"/> 341 Nutrient Deficiency Diseases | <input type="checkbox"/> 349 Genetic and Congenital Disorders |
| <input type="checkbox"/> 304 Hx of Preeclampsia | <input type="checkbox"/> 342 Gastro-Intestinal Disorders | <input type="checkbox"/> 351 Inborn Errors of Metabolism <input type="checkbox"/> 361 Depression |
| <input type="checkbox"/> 311 Hx of Preterm | <input type="checkbox"/> *343 Diabetes Mellitus | <input type="checkbox"/> 352 Infectious Diseases <input type="checkbox"/> 362 Dvlpmntl, Sens.or Motor Delays |
| <input type="checkbox"/> 312 Hx of Low Birth Wt. | <input type="checkbox"/> 344 Thyroid Disorders | <input type="checkbox"/> 353 Food Allergies <input type="checkbox"/> 371 Maternal Smoking |
| <input type="checkbox"/> 321 Hx of Spon. Abortion, Fetal or Neonatal Loss | | <input type="checkbox"/> 354 Celiac Disease <input type="checkbox"/> 372 Alc. & Illegal Drug Use |
| <input type="checkbox"/> *331Pregnancy at a Young Age | <input type="checkbox"/> 345 HTN or PreHTN | <input type="checkbox"/> 355 Lactose Intolerance <input type="checkbox"/> 381Oral Health Conditions |
| <input type="checkbox"/> 332 Closely Spaced Pregnancies | <input type="checkbox"/> 346 Renal Disease | <input type="checkbox"/> 356 Hypoglycemia |
| <input type="checkbox"/> 333 High Parity and Young Age | <input type="checkbox"/> *347 Cancer | <input type="checkbox"/> 357 Drug Nutrient Interactions |
| <input type="checkbox"/> 335 Multifetal Gestation | <input type="checkbox"/> 348 Central Nervous System Disorders | <input type="checkbox"/> 358 Eating Disorders |
| <input type="checkbox"/> 337 Hx of Birth w/ Lg for Gestational Age Infant | | <input type="checkbox"/> 359 Recent Major Surgery, Trauma, Burns |
| <input type="checkbox"/> *339 Hx of Birth w/ Nutr. Related Congenital or Birth Defect | | <input type="checkbox"/> 360 Other Medical Conditions |

Nutrition and Other Risk Factors

- | | |
|--|--|
| <input type="checkbox"/> 401 Failure to Meet Dietary Guidelines | <input type="checkbox"/> 901 Recipient of Abuse |
| <input type="checkbox"/> 427.01 Consuming Suppl. w/ Potentially Harmful Consequences | <input type="checkbox"/> *902 Woman or Infant/Child of Primary Caregiver w/ Limited Ability to |
| <input type="checkbox"/> 427.02 Diet Very Low Calories/Nutrients; Impaired Intake/Absorption | <input type="checkbox"/> 904 Env. Tob. Smoke Exposure |
| <input type="checkbox"/> *427.03 Compulsively Ingesting Non-Food Items (PICA) | |
| <input type="checkbox"/> 427.04 Inadequate Essential Vit/Min | |

<u>Nutrition Education</u>	
Method: <input type="checkbox"/> Ind - F/U <input type="checkbox"/> HH - F/U	
<u>Topic</u>	
<u>Referrals</u>	
<u>Food Package</u> <input type="checkbox"/> Milk or Lacto-free / Soy / Evap / Pwdr / UHT <input type="checkbox"/> Cheese <input type="checkbox"/> Eggs <input type="checkbox"/> PN Butter <input type="checkbox"/> Juice <input type="checkbox"/> Cereal <input type="checkbox"/> Yogurt <input type="checkbox"/> Fish <input type="checkbox"/> Beans <input type="checkbox"/> CVB <input type="checkbox"/> Whole Grains	<u>Type of Formula/Medical Food:</u> <u>Amount per day:</u>
<u>Notes</u>	
<input type="checkbox"/> NE Counseling Note <input type="checkbox"/> Ind Care Plan/Follow Up <input type="checkbox"/> BF Note	<u>General Note:</u>
<u>Benefit Issuance:</u> <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-Monthly <input type="checkbox"/> Tri-Monthly	
Schedule Appointment:	