LITTLE LEAF LACTATION - POSTNATAL WELLNESS & LACTATION SUPPORT

CONSENT FORM

Date

Clients Name

First Name

Last Name

Clients Date Birth

DD/MM/YYYY

Infant/Childs Name (if applicable)

As a recipient of postnatal care and/or lactation support, please review the following information carefully:

I understand that I am receiving postnatal care and/or lactation support services that may include the following: support for postpartum recovery, assistance with infant/child feeding, and guidance aimed at promoting the health and well-being of both myself and my infant/child.

Services may be provided in person, via telehealth, or a combination of both, depending on availability and individual needs/preferences.

I understand that all personal health information shared during care will remain confidential and will not be released without my written consent, unless required by law.

I understand that while every effort will be made to provide evidence-based and individualised care, outcomes may vary. I acknowledge that some discomfort may occur during assessment or interventions (e.g., breast examination or feeding adjustments), but all techniques will be explained beforehand.

I understand that I may decline or withdraw consent at any time without affecting my access to other care.

By signing below, I acknowledge that:

- I have read and understood the information provided about postnatal care and lactation support services.
- I have had the opportunity to ask questions about the services provided and these have been answered to my satisfaction.
- I understand the nature, purpose, risks, and benefits of these services.
- I voluntarily consent to receive postnatal care and lactation support from Little Leaf Lactation.
- I also consent to my infant/child receiving assessment and support related to feeding, well-being, and newborn/infant care as part of these services.

Client (Parent/Guardian) Signature: _____ Date: _____

Provider Signature: _____ Provider Name: *Penny Estillore* RN RM IBCLC