

CORPORATE LACTATION PROGRAMS

Lactation Consultants of Atlanta, Inc.

THE HOME DEPOT BREASTFEEDING PROGRAM

PLEASE FAX MONTHLY REPORT FORM TO 678-921-2839

EMPLOYEE NAME _____ REPORT DATE _____

E-MAIL ADDRESS _____ WORK PHONE _____

BABY'S BIRTHDATE _____ REPORT # 1 2 3 4 5 6 7 8 9 10 11 12

NUMBER OF MONTHS PUMPING AT WORK: 0 1 2 3 4 5 6 7 8 9 10 11 12 13+

NUMBER OF PUMPING TIMES PER DAY THIS MONTH: 0 1 2 3 4 5 6 7 8 9 10 11 12 13+

WE ARE BREASTFEEDING: EXCLUSIVELY / MAJORITY / PARTIALLY / FOOD ADDED / NOT BREASTFEEDING

MY BREASTFEEDING EXPERIENCE IS: NOT DELIVERED / VERY SATISFACTORY / SATISFACTORY / UNSATISFACTORY

BREASTFEEDING AT THE WORKSITE IS GOING: WELL / ADEQUATE / POOR / NEED HELP / NOT AT WORK YET

CHANGES THAT HAVE HAPPENED THIS MONTH:

- INCREASE IN MILK SUPPLY DECREASE IN MILK SUPPLY BABY'S GROWTH SPURT
 BABY'S NURSING INTEREST WEANING OTHER

DIFFICULTIES THAT YOU HAVE EXPERIENCED THIS MONTH:

- PUMPING DIFFICULTIES SUPERVISOR DIFFICULTIES WORK SCHEDULE CHANGES
 PERSONAL ILLNESS BABY'S ILLNESS OTHER

ILLNESS DATE	ILLNESS TYPE (COLD, EAR INFECTION, ETC)	SEVERITY (SEE BELOW)	WHO WAS ILL	MEDICATIONS NEEDED	DAYS ABSENT FROM WORK	NURSING (SEE BELOW)

SEVERITY

MILD - SOME SYMPTOMS, NO DOCTOR VISIT NEEDED

MODERATE - DOCTOR VISIT WITH CONFIRMED DIAGNOSIS BY DOCTOR OR NURSE PRACTICIONER

SEVERE - HOSPITALIZATION

NURSING

EB - EXCLUSIVELY BREASTFED - BREASTMILK ONLY

MB - MAJORITY BREASTFED - AT LEAST 6 BREASTFEEDINGS/BREASTMILK FEEDINGS IN 24 HOURS

PB - PARTIALLY BREASTFED - AT LEAST 2-4 BREASTFEEDINGS/BREASTMILK FEEDINGS IN 24 HOURS

FA - FOODS ADDED

ABF - FORMULA FED/NO BREASTMILK

PLEASE SUBMIT REPORTS MONTHLY TO CATHERINE WARREN, PROGRAM MANAGER

THESE MONTHLY REPORTS ARE A MANDATORY PART OF THE PROGRAM AND IT IS NECESSARY TO RECEIVE EACH REPORT TIMELY AS YOUR BABY GROWS. REPORTS ARE DUE THE FIRST OF EACH MONTH!

FAX REPORTS TO 678-921-2839 OR MAIL TO 1950 SPECTRUM CIRCLE, SUITE 400, MARIETTA, GA 30067
QUESTIONS OR ASSISTANCE? CALL 678-921-2838