One Month Checklist

Date of Visit: _____

Nurse Code: _____ Age of Child: _____
Client Initial: _____ Client number: _____
Birth weight: _____ Birth length: _____
Current weight: _____ Current length: _____

INFANT FEEDING

1. Look at antenatal visit around choice of feeding and ask what changed their mind or influenced them about this choice._____
   _____

2. How is your child currently feeding?
   - ☐ Exclusively breastfeeding? Go to 6
   - ☐ Complementary Feeding Go to 3
   - ☐ Stopped breast feeding since last visit – now formula feeding Go to 10
   - ☐ Formula feeding Go to 13

If yes discuss exclusive breastfeeding for first 6 months/continuation for 12 months and beyond

Complementary Feeding

3. When did you start complementary feeding? _____

4. Why did you start to complementary feed?
   - ☐ Attachment issue
   - ☐ Thrush
   - ☐ Number of feeds
   - ☐ Breast Fullness/ Engorgement
   - ☐ Milk Supply
   - ☐ Sleep and Settling
   - ☐ Lack of professional advice
   - ☐ Breastfeeding in public
   - ☐ Refusal
   - ☐ Mastitis
   - ☐ Differing advice - professionals
   - ☐ Lack of support - partner
   - ☐ Lack of support - family & friends
   - ☐ Other

5. Did you seek advice or support before you commenced complementary feeding?
   - ☐ Yes
   - ☐ No

   - ☐ Midwife
   - ☐ Child & Family nurse
   - ☐ Pharmacist
   - ☐ GP
   - ☐ Family
   - ☐ Friend
   - ☐ Other

Discuss issues relating to complementary feeding and possibility of re-establishing full breastfeeding. If re-establishing breastfeeding refers to clinic, intake, ABA, printed handout.

6. Have you any questions, concerns or issues with breastfeeding?
   - ☐ Painful nipples
   - ☐ Thrush
   - ☐ Refusal
   - ☐ Mastitis
   - ☐ Length of feeds
   - ☐ White spot / milk blister
   - ☐ Sucking problems
   - ☐ Blocked milk ducts
   - ☐ Number of feeds
   - ☐ Expressing
   - ☐ Oversupply
   - ☐ Fullness/ engorgement
   - ☐ Attachment / positioning
   - ☐ Sleep & settling
   - ☐ Low supply
   - ☐ Other _____

Discuss any of the above issues including what to expect in the next few months sleep cycles, night feeds, feeding patterns, tired signs, crying, settling strategies, supply changes, behavioural changes.

7. Has anything else made breastfeeding a more difficult experience than you expected?

☐ Yes ☐ No

☐ Lack support - partner ☐ Differing advise – health workers

☐ Lack support – family/friends ☐ Lack of advice – health workers

☐ Breastfeeding in public ☐ Other

8. If previously working has you thought about breastfeeding and work?

☐ Yes ☐ No ☐ N/A

9. Will work affect how long you breastfeed for?

☐ Yes ☐ No

Discuss work, breastfeeding & expressing

Formula Feeding

10. Including times of weaning, what is the total time your baby was breastfed in months and weeks?

_____days _____weeks _____ months

11. Why did you change to formula feeding?

☐ Attachment issue ☐ Sleep and Settling ☐ Lack support – partner

☐ Thrush ☐ Refusal ☐ Work

☐ Number of feeds ☐ Mastitis ☐ Breastfeeding in public

☐ Fullness/ Engorgement ☐ No professional advice ☐ No support of family

☐ Milk Supply ☐ conflicting advice ☐ No support of friends

☐ Other _____

12. Did you seek advice or support before you commenced formula feeding?

☐ Yes ☐ No

☐ Midwife ☐ GP ☐ Family

☐ Child & Family nurse ☐ Pharmacist ☐ Friends

☐ Other _____

13. Do you have any questions, concerns or issues relating to formula feeding your new baby?

☐ Yes ☐ No

☐ Sucking problems ☐ Positioning

☐ Refusal ☐ Length of feeds

☐ Vomiting ☐ Sleep and Settling

☐ Number of feeds ☐ Other

Discuss any of the above issues including what to expect in the next few months growth spurts, sleep cycles, night feeds, sleep needs, feeding patterns, tired signs, crying, settling strategies, and behavioural changes. Discuss the importance of correct formula preparation and amount.

Introduction of Solids

14. Can you tell me what the recommendations are for the introduction of solids?

☐ Yes _____ months

☐ No

Discuss recommendations of starting solids at 6 months and reasons for this

YOUR BABY & PHYSICAL ACTIVITY

15. How often does your baby spend time on their tummy when they are awake?
    - ☐ less than 2 days a week
    - ☐ 3 -4 days a week
    - ☐ 5 -6 days a week
    - ☐ Daily

16. Are you confident about putting your baby on their tummy?
    - ☐ Yes
    - ☐ No

Discuss supporting babies' bodies and senses. Reinforce SIDs and sleep time

YOUR PHYSICAL ACTIVITY & NUTRITION

17. What type of delivery did you have?
    _____

18. Are you doing pelvic floor exercise?
    - ☐ Yes
    - ☐ No

19. Have you recommenced any form of exercise or physical activity?
    - ☐ Yes
    - ☐ No

20. Does the family get exercise together?
    - ☐ Yes
    - ☐ No

Discuss physical recovery since birth of baby; discuss appropriate exercises, pelvic floor exercise or abdominal surgery recovery. Discuss ideas for physical activity & nutrition for whole family.

SOCIAL SUPPORT

21. What involvement with the baby does your partner have?
    _____
    _____

22. Do you have a supportive family?
    - ☐ Yes
    - ☐ No

23. Do you have friends with children the same age and do you spend time with them?
    - ☐ Yes
    - ☐ No

24. Are you in contact with Child & Family Nurses who work out of local baby clinics?
    - ☐ Yes
    - ☐ No

25. Have you visited your local doctor in regards to anything to do with your baby since you arrived home?
    - ☐ Yes
    - ☐ No
    - ☐ Medical centre

Discuss importance of supportive environments

COMMENTS

_____
_____
_____

Other topics discussed:

_____
_____
_____

Signature: _____