Co-Lactation Infant Feeding Plan

My name is_____and my goal is to co-feed my baby with my (partner status) _____ (name) _____.

The benefits of breastfeeding are very important to us and our baby. We would like to have our guidelines supported as long as it is medically safe. We also would like to ensure that my milk supply is well-established, while supporting _____ in learning how to nurse and bond with our new baby. Because of this, some things in our feeding plan are the same as other peoples, and some are different.

ROUTINE/CHECK ALL THAT APPLY:

- ☐ **Skin to skin:** please place our baby skin to skin on my chest after delivery. Please do check-ups and procedures on our baby while they are skin to skin, when possible.
- ☐ **Emergency Cesarean:** if I am unable to hold the baby skin to skin at birth, please allow my (partner status)_____, (name)_____ to do so and latch for the first time.
- ☐ **Exclusive Breastfeeding:** our goal is to exclusively breastfeed our baby. Please do not give my baby any formula before speaking to us about it.
- ☐ **No bottles or pacifiers:** please do not give pacifiers or bottles without speaking with us first.
- ☐ **Feed on cue:** please help me to learn the signs that my baby is hungry and feed my baby when they are ready to eat.
- ☐ **Rooming in:** please help our baby and I stay in our room together 24 hours per day.

FOR CO-LACTATION/CHECK ALL THAT APPLY:

- ☐ **At the time of delivery,** my (partner status)_____, (name)_____ is making _____mL per day of milk.
- ☐ **Initial skin to skin and latch** will be done by _____, if we are medically able.
- ☐ **If I am not available after birth to do skin to skin and latch**, please allow my _____, (name)_____ to do so *and latch for the first time*.
- ☐ **After the first latch,** we would like _____ to primarily feed the baby at the breast.
- ☐ **After the first latch,** we would like to both feed at the breast. We know that if we do this, whoever is not feeding at the breast will need to hand-express or pump milk, and this may result in a decreased milk supply. We also understand that if my (partner status)_____, (name)_____ is not making milk, a supplemental nursing system will need to be used. In all cases, baby's weight will need to be closely monitored.
- ☐ **Please provide** my (partner status)_____, (name)_____ help with a supplemental nursing system while in the hospital.
- ☐ **After we go home,** we would like to _____ _____.

This plan has been discussed with my provider: _____
My baby's provider/pediatrician will be: _____

- ☐ Discuss with baby's provider/pediatrician