Government of the Republic of Trinidad and Tobago
Ministry of Health

NATIONAL BREASTFEEDING FORM B
Criteria adapted from the National Breastfeeding Policy

FORM B: POST DELIVERY RECORD (To be completed during the Postnatal ward)

NAME:_____ **AGE:** _____ **D.O.B:**_____**(dd/mm/yy)**
NATIONALITY: _____ **COUNTY:**_____ **PARITY:** _____
HEALTH FACILITY:_____ **CLINIC NO:**_____ **HOSPITAL NO:** _____

INFANT'S NAME:_____ **AGE:** _____ **D.O.B:**_____**(dd/mm/yy)**
NATIONALITY: _____ **COUNTY:**_____
HEALTH FACILITY:_____ **CLINIC NO:**_____

FORM B: POST DELIVERY

	Client was facilitated with:	**YES**	**NO**
1.	Immediate and uninterrupted 'skin-to-skin' in the first hour after delivery		
2.	Initiation of breastfeeding within the first hour of life		
3.	Appropriate skills of positioning and latching for successful breastfeeding		
4.	Ability to identify signs that her infant is adequately breastfed		
5.	Demonstration on how to express breast-milk		
6.	Knowledge of medical indications for supplementation and 'cup feeding'		
7.	'Rooming-in' for the duration of hospitalization		
8.	Recognition of baby's feeding cues		
9.	Knowledge of the risks associated with not breastfeeding and the use of bottles, teats and pacifiers		
10.	Referral to ongoing breastfeeding support upon discharge		

_____ _____ _____
Name in BLOCK Letters Signature Date (dd/mm/yy)

_____
Designation