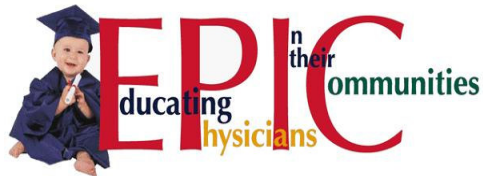


# *Breastfeeding Education for Your Practice!*



## **EPIC Breastfeeding Education Program Now Available for Your Office**

- The Georgia Chapter of the American Academy of Pediatrics has launched a new EPIC program on Breastfeeding. This program is modeled on our successful EPIC Immunization program.
- Physician-Nurse/Lactation Counselor Teams will provide education to ensure everyone in your office understands the importance of supporting breastfeeding mothers, increasing Georgia's breastfeeding rates, and current breastfeeding guidelines.
- These 1-hour sessions are free and presented at your convenience for your office, usually over the lunch hour.
- Each office will receive a Breastfeeding Resource Kit as part of the presentation.
- CME credit available for physicians

We hope you'll participate in this Chapter effort to boost breastfeeding rates in Georgia and provide an excellent educational experience for you and your office staff.

To schedule your free EPIC Breastfeeding Program in your office, just fax the completed forms to 404/249-9503. Then the EPIC staff will contact you to arrange the details. For more information, contact Kristy Fors, RN, IBCLC, Breastfeeding EPIC Program Director at 404-881-5095 or email: [kfors@gaaap.org](mailto:kfors@gaaap.org).

Thank you,

*Robert Wiskind*

Robert Wiskind, M.D., FAAP  
Breastfeeding Coordinator  
Georgia Chapter – American Academy of Pediatrics

**Request for EPIC Breastfeeding Education Presentation**

**Please provide us with the following information so that we can make the appropriate arrangements (training team, materials, etc.) for your program. Our office will contact you as soon as possible to confirm the date of your presentation. Thank you and we look forward to providing you with this educational opportunity.**

**Note: Offices should dedicate a minimum of 1.0 hour for the Program**

Date of Request: \_\_\_\_\_ Name of Person Making Request: \_\_\_\_\_

Practice/Facility Name: \_\_\_\_\_

Names of Physicians in Practice: \_\_\_\_\_

Type of Practice: \_\_\_\_\_ Family Medicine \_\_\_\_\_ Pediatric \_\_\_\_\_ OB/GYN \_\_\_\_\_ Other \_\_\_\_\_

Type of Facility: \_\_\_\_\_ College \_\_\_\_\_ Technical College \_\_\_\_\_ Residency Program \_\_\_\_\_ Other \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

District/County: \_\_\_\_\_

Possible Dates for Presentation: 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_

Best Time of Day: 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_

Approximate Number of Attendees: \_\_\_\_\_

Approximate # of Attendees by category: (This will allow us to send the appropriate certificates for your office)

\_\_\_\_\_ Physicians \_\_\_\_\_ NP/PA \_\_\_\_\_ RN/LPN \_\_\_\_\_ MA/MT \_\_\_\_\_ Office Staff \_\_\_\_\_ Other \_\_\_\_\_

Location of Presentation if other than office location listed above:

\_\_\_\_\_  
\_\_\_\_\_

Training Site Contact Person if different from person making request:

Name \_\_\_\_\_ Phone: \_\_\_\_\_ E-mail \_\_\_\_\_

## Pre-EPIC Breastfeeding Program Survey

**Please complete and return this Survey with your EPIC program request. Your answers to this survey will help our trainers provide you with the best information to assist your office with Breastfeeding education! Thank you.**

Date \_\_\_\_\_

Type of Practice \_\_\_\_\_ Primary Occupation \_\_\_\_\_

How long have you been working in this capacity? \_\_\_\_\_

1. Requested topic(s) of interest:

- |   |  |
|---|--|
| <input type="checkbox"/> Benefits of Breastfeeding          | <input type="checkbox"/> Racial disparity            |
| <input type="checkbox"/> Contraindications to Breastfeeding | <input type="checkbox"/> Barriers of Breastfeeding   |
| <input type="checkbox"/> Medications and Breastfeeding      | <input type="checkbox"/> Support for working mothers |
| <input type="checkbox"/> Breastmilk supply issues           | <input type="checkbox"/> Community resources         |
| <input type="checkbox"/> Latching issues/positioning        | <input type="checkbox"/> Other _____                 |

2. What is your comfort level dealing with breastfeeding mothers? **Very**    **Somewhat**    **Not at All**

3. Did you receive any breastfeeding education during your residency program?    **Yes**    **No**

4. Did any of your staff receive any breastfeeding education during their training?    **Yes**    **No**

5. Do you think your attitude about breastfeeding affects your patients' decision to breastfeed?    **Yes**    **No**

6. Do you systematically collect information about breastfeeding?    **Yes**    **No**

7. What resources do you use in your practice for breastfeeding education?

- |  |   |
|--|---|
| <input type="checkbox"/> CDC Redbook                               | <input type="checkbox"/> AAP/OB/FP Policy Statements                  |
| <input type="checkbox"/> AAP Breastfeeding Handbook for Physicians | <input type="checkbox"/> Breastfeeding and Human Lactation/Lawrence   |
| <input type="checkbox"/> LaLeche Question and Answer Book          | <input type="checkbox"/> Breastpump Company Reps                      |
| <input type="checkbox"/> Amy Spanglers' Educational Materials      | <input type="checkbox"/> The CDC Guide to Breastfeeding Interventions |
| <input type="checkbox"/> The Breastfeeding Atlas                   | <input type="checkbox"/> CDC Red Book                                 |
| <input type="checkbox"/> Medications and Mothers' Milk/Hale        | <input type="checkbox"/> Other _____                                  |
| <input type="checkbox"/> Grady Poison Control                      | Websites _____  |
| <input type="checkbox"/> PDR                                       | _____   |
|  | _____   |

8. Which of the following referral sources does your practice provide to patients for lactation services?

- |  |  |
|--|--|
| <input type="checkbox"/> Peer Counselors/WIC           | <input type="checkbox"/> WIC office                      |
| <input type="checkbox"/> Hospital Lactation Consultant | <input type="checkbox"/> Other _____                     |
| <input type="checkbox"/> Private Lactation Consultant  | <input type="checkbox"/> Certified Lactation Consultant  |
| <input type="checkbox"/> Breastfeeding Support Group   | <input type="checkbox"/> Rental of Equipment or supplies |
| <input type="checkbox"/> Websites _____                | <input type="checkbox"/> Breastfeeding Hot Line          |
| _____  |  |

9. Do you ask your patients about breastfeeding? **Yes** **No**  
If so, how and when? \_\_\_\_\_
10. Is breastfeeding assessment part of your visit with your patient? If so, do you document the assessment? \_\_\_\_\_  
\_\_\_\_\_
11. When do most women make the decision to breastfeed? Preconception **1<sup>st</sup> Trimester** **2<sup>nd</sup> Trimester**  
(may circle one or more answer) **3<sup>rd</sup> Trimester**
12. Do you play an active role in educating your patients about breastfeeding? **Yes** **No**  
If so, how and when?  
\_\_\_\_\_  
\_\_\_\_\_
13. How important do you think breastfeeding education is for your patients? **Very** **Somewhat** **Not at All**
14. Has your office received any breastfeeding education in the last 2 years? **Yes** **No**  
If yes, please describe the information received and who received this information.  
\_\_\_\_\_
15. How would you describe the location of your primary practice? **Urban, inner city**  
**Urban, not inner city** **Suburban** **Rural** **Other**\_\_\_\_\_
16. What do you estimate is the percent of your patients receiving WIC support? \_\_\_\_\_%
17. What do you estimate is the percent of your patients receiving Medicaid? \_\_\_\_\_%
18. Is Breastfeeding promotion worth your effort? **Yes** **No**

**Please fax Program Request Form and Pre-Survey to:**

**Breastfeeding EPIC Program  
1330 West Peachtree Street NW Suite 500  
Atlanta, GA 30309-2904  
Attn: LaVerne Livingston; Fax: 404-249-9503**

**For additional information, contact:  
Kristy Fors, RN, IBCLC @ 404-881-5095 or  
Email: [kfors@gaaap.org](mailto:kfors@gaaap.org)**

**Thank You!**