Intern Name: _____

Month/Year: _____

Consult Log

Clinical Lactation Training Program

	DATE	PT ACUITY	PARA/BF	DOB/GA	BW	UNIT	REASON FOR CONSULT/COMPETENCY SKILL SET	O/S/I	LC Initial	TOTAL HRS PER DATE
1										
2										
3										
4										
5										
6										
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