Georgia Department of Public Health

GEORGIA WIC

EATHEALTHYGROWHEALTHYLIVEHEALTHY

Peer Counselor Observation Checklist

Peer Counselor: _____ **Clinic:** _____ **Month:** _____

WIC ID: _____ **Participant Category:** _____ **Reviewer:** _____

BREASTFEEDING COUNSELING	RATING	COMMENTS
Personalizes session by using participant's name & background information.	Yes ☐ No ☐	
Prioritizes topics to discuss	Yes ☐ No ☐	
Asks open-ended questions	Yes ☐ No ☐	**Rating Scale:** Frequently ☐ Rarely ☐ Never ☐
Probes using appropriate questions to assess mother's situation.	Yes ☐ No ☐	
Uses counseling skills such as reflective listening and affirmation of feelings appropriately.	Yes ☐ No ☐	
Education was based on participant responses	Yes ☐ No ☐	
Counseling: Accurate information provided	Yes ☐ No ☐	
Counseling: Culturally appropriate information provided	Yes ☐ No ☐	
Gave Handouts related to participant needs and interests	Yes ☐ No ☐	
Uses breast models, dolls when appropriate	Yes ☐ No ☐	
Reviews previous infant feeding experiences and/or that of other family or friends.	Yes ☐ No ☐	
Explores mother's current and future feeding plan for her infant.	Yes ☐ No ☐	
Explores participant's thoughts of information shared during counseling session.	Yes ☐ No ☐	

BREASTFEEDING COUNSELING	RATING	COMMENTS
Explores participant's thoughts and feelings about breastfeeding.	Yes □ No □	
New breastfeeding goal documented?	Yes □ No □	
Ends the counseling session on a positive note and offers appropriate follow-up and referrals as needed.	Yes □ No □	
Properly referred to senior Lactation Consultant when needed.	Yes □ No □ N/A □	

WHAT WENT WELL
WHAT CAN BE DONE DIFFERENTLY
WHAT I WILL WORK ON - Improvement Goal(s)

Peer Counselor signature: _____ Date: _____

Reviewer signature: _____ Date: _____