# TONGUE-TIE CLINIC REFERRAL FORM

## Patient details:
- Date:
- Mother's Name:
- Contact Phone:
- Father's Name:
- Baby's First Name:
- Surname:
- DOB:
- Male □ Female □
- Place of birth:
- Gestation
- Birth Weight:
- Current Weight:

## Reason for referral:
- **Maternal issues:**
  - Nipple pain □
  - Ulceration □
  - Mastitis (current or previous) □
  - Poor supply □
- **Infant issues:**
  - Can't latch □
  - Can't maintain latch □
  - Aerophagia □
  - Colic / Reflux □

## Feeding:
- Exclusive BF □
- Pumping □
- Using shields □
- Supplementation with formula □
- % of feeds non BF □
- Exclusive formula feeding □

## Tongue functionality / restriction:
- Lateralisation □
- Elevation □
- Oral anatomy: Normal / Abnormal

## Ankyloglossia:
- Anterior □
- Posterior □
- Comment

## Referring practitioner:
- Consultant □
- GP □
- CMO □
- Other □
- Name:
- Address:
- Contact Phone Number