Beacon Hospital for kids

TONGUE-TIE CLINIC REFERRAL FORM

Patient details:

Date :

Mothers 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:	Infant Issues:
Nipple pain ☐	Can't latch ☐
Ulceration ☐	Can't maintain latch ☐
Mastitis (current or previous) ☐	Aerophagia ☐
Poor Supply ☐	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