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Department of Paediatric Surgery

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Tongue-tie Service referral form

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Important:** | | | | |
| * We only accept referrals from NHS Breastfeeding Specialists (i.e. Lactation Consultant, Infant Feeding Advisor and Breastfeeding Counsellor). * GP / Hospital consultant referrals only accepted with feeding assessment from breastfeeding specialist (as named above). * Non-NHS referrals must be accompanied by a supporting GP referral to ensure funding for the procedure. * We try to see properly worked up referrals in our next available clinic. Incomplete referrals will result in a delay. | | | | |
| **About the patient (baby)** | | | | |
| Baby’s gender |  | | | |
| Baby’s name |  | | | |
| Date of birth |  | Place of Birth | |  |
| NHS Number |  | KCH Hosp. ID | |  |
| GP name/ address/ email address |  | | | |
| **About the parents** | | | | |
| Full names of baby’s parents |  | | | |
| Postal address |  | | | |
| Phone number |  | | | |
| Email address |  | | | |
| Is an interpreter required? | Yes | | No | |
| If yes, specify language: | | | |
| **Referrer’s Information** | | | | |
| Referrer’s full name |  | | | |
| Referrer’s job title |  | | | |
| Name of referrer’s NHS commissioning organisation / postal address |  | | | |
| Referrer’s email address |  | | | |
| Referrer’s phone number |  | | | |

Please provide the following information about the patient:

|  |  |  |  |
| --- | --- | --- | --- |
| 1. Has baby had frenulotomy performed previously? | Yes | No | |
| 1. If yes, how many times has frenulotomy been performed previously? |  | | |
| 1. Is baby aged 1 week or more at time of referral? | Yes | No | |
| 1. Has baby received vitamin K prophylaxis? | Oral | IM injection | No |
| Doses given? |
| 1. Are there any other significant medical problems?   *Please give details.* |  | | |

|  |  |  |  |
| --- | --- | --- | --- |
| 1. Date of first feeding assessment:   \_\_\_\_\_\_\_\_\_\_\_  *Note: Babies need to have been assessed by a Breastfeeding Specialist with observation of feed and initial feeding plan made and subsequent review of that plan.* | | | |
| 1. Has a breastfeed been observed? | Yes | | No |
| 1. What plan was put in place to initiate and maintain breastfeeding?   *(Please tick as many options that applies to mother)* |  | Advice on positioning and attachment | |
|  | Plan to increase milk supply Galactagogue food / medication and or pumping | |
|  | Supplementation with formula advice | |
|  | Supplementation with expressed breast milk advice | |
|  | Importance of skin to skin | |
|  | Nutritive and non-nutritive sucking | |
| 1. Is baby using nipple shields? | Yes | | No |
| 1. Are there any supplemental feeds? | Yes | | No |
| 1. Volume and number of expressed breast milk feeds: | mls | | Frequency per 24 hrs |
| 1. What is the volume of formula feeds frequency per day? | mls | | Frequency per 24 hrs |
| 1. Method of supplementation |  | Bottle | |
|  | Finger Feeding | |
|  | SNS | |
| Other: | | |
| 1. List other key difficulties in breast feeding: |  | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1. Date of second assessment/review:   \_\_\_\_\_\_\_\_\_\_\_  *Note: a face-to-face (not by telephone) review of feeding plan with observation of a feed within 5-7 days before referral is preferred. Include details of how the feeding plan / interventions have assisted breastfeeding or not. Attach any additional copies of your feeding/treatment plan and details of the outcome of its review.* | | | | | |
| 1. Please provide baby’s last known weight at time of referral: | kg | | Date weight taken: | | |
| 1. What plan is now in place to maintain breastfeeding?   *(Please tick as many options that applies to mother)* |  | Advice on positioning and attachment | | | |
|  | Plan to maintain milk supply Galactagogue food / medication and or pumping | | | |
|  | Supplementation with expressed breast milk advice | | | |
|  | Importance of skin to skin | | | |
|  | Nutritive and non-nutritive sucking | | | |
| 1. Has formula supplementation been reduced? | Yes | | | No | N/A |
| 1. Volume and number of expressed breast milk feeds: | mls | | | Frequency per 24 hrs | |
| 1. Volume and frequency of formula feeds: | mls | | | Frequency per 24 hrs | |
| 1. Method of supplementation |  | Bottle | | | |
|  | Finger Feeding | | | |
|  | SNS | | | |
| Other: | | | | |
| 1. What steps have been taken to maintain or increase milk supply? |  | | | | |
| 1. Has milk supply increased? | Yes | | | No | N/A |
| 1. How many times does baby go to the breast per day? *(Please see important note on the last page of this form for further details).* |  | 0-3 times in 24 hours | | | |
|  | 4-9 times in 24 hours | | | |
|  | 10+ times in 24 hours | | | |
| 1. List other key difficulties that are still present in breast feeding: |  | | | | |
| 1. Is mother intending to continue breastfeeding? | Yes | | | No | |
| 1. For how long does mother intend to breastfeed |  | | | | |
| 1. Description of tongue tie: |  | | | Anterior (visible) | |
|  | | | Posterior | |
| 1. Tongue mobility observed: |  | | | | |

**Important**

There is a high demand for appointments. Priority will be given to referrals that meet the criteria. To ensure frenulotomy-readiness mothers should be supported to offer babies a breastfeed for every feed. Formula supplements should be less than 50% of total daily requirement. This will assist mothers to progress quickly after frenulotomy.

Babies cannot be referred to the Tongue-tie Clinic for speech concerns.

**Post-frenulotomy**

Parents will be asked to contact you once an appointment has been confirmed with the Tongue Tie Clinic. They will be advised to arrange follow-up with their referring team within 7 days.

***Sending your referral form***

Please email your completed form to [kch-tr.tonguetieclinic@nhs.net](mailto:kch-tr.tonguetieclinic@nhs.net)

Your referral will be reviewed by the Tongue-tie Clinic Lactation Consultant, Mr Patel, or one of his registrars.