

Department of Paediatric Surgery

**Mr Shailesh Patel**, Consultant Surgeon

Secretaries: 020 3299 6550

Email: kch-tr.tonguetieclinic@nhs.net

Denmark Hill

London

SE5 9RS

Switchboard: 020 3299 9000

Tongue-tie Service referral form

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| **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.* |  |

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| 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

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