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| **Referral form for Tongue Tie Assessment Clinic**  **Please ensure all the boxes are filled in because the appointment is generated from this form**  **Failure to Complete all details/questions will result in the referral being rejected**  **NB. Referrals for future potential problems e.g. speech difficulties will not be accepted** | |
| Baby’s Name: | Mothers Name: |
| NHS number: | Mothers NHS number: |
| Birth details | |
| Baby’s Date of birth | Gestation at birth: |
| Baby’s Gender: | Baby’s Ethnicity; |
| Baby’s Age at referral: |  |
| Address: | GP address: |
| Post code | Post code: |
| **Email address:** | |
| **Contact number:** | |
| **Reason for referral** | |
| Breastfeeding issue | Formula feeding issue |
| **Please answer ALL the following questions**:  What is the issue?  What feeding plan has been put in place in discussion with the mother?  Current feeding method?  Is lactation good?  Have you devised an individualised feeding plan? Or provided a plan to protect lactation until she has an appointment to attend a clinic? Please describe | |

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| **Please Complete for ALL babies: Feeding assessment tool** | | | |
| What to look for/ask about | | YES | NA |
| **The baby**: | | | |
| Has at least 8-12 feeds in 24hours\* | |  |  |
| Is generally calm and relaxed when feeding and content after feeds | |  |  |
| Will take deep rhythmic sucks and you will hear swallowing\* | |  |  |
| Will generally feed for between 5 and 40 minutes and will come off the breast spontaneously | |  |  |
| Has a normal skin colour and is alert and waking for feeds | |  |  |
| Has not lost more than 10% weight | |  |  |
| **Babies nappies** | | | |
| At least 5-6 heavy, wet nappies in 24hours\* | |  |  |
| At least 2 dirty nappies in 24 hours, at least £2 coin size, yellow and runny, usually more\* | |  |  |
| **Mothers breasts** | | | |
| Breasts and nipples are comfortable | |  |  |
| Nipples are the same shape at the end of the feed as the start | |  |  |
| **Other** | | | |
| Is the use of dummy/nipple shields/infant formula impacting on breastfeeding | |  |  |
| Has a full breastfeed been observed | |  |  |
| Has positioning and attachment been revisited | |  |  |
| Is a feeding plan in place and documented in the Child Health Record | |  |  |
| \***This Baby Friendly Assessment Tool was designed for use around day 5,**  **if used at other times:** | | | |
| **Wet nappies**  Day 1-2 = 1-2 or more in 24 hours  Day 3-4 = 3-4 or more in 24 hours, heavier  Day 6 plus = 6 or more in 24 hours, heavy | **Stools/dirty nappies**  Day 1-2 = 1 or more in 24 hours, meconium  Day 3-4 = 2 (preferably more) in 24 hours changing stools  Day 5 onwards = (preferably more) in 24 hours mustard coloured/runny | | |
| **Sucking pattern:**  Swallows may be less audible until milk comes in day 3-4  **Feed frequency**  Day 1 at least 3-4 feeds  After day 1, young babies will feed often and the pattern and number of feeds will vary from day to day. Being responsive to the baby’s need to breastfeed for food, drink, comfort and security will ensure a good milk supply and a secure happy baby. | | | |

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| **Referral checklist** | | YES | NO |
| Is there a family **history of heredity clotting disorders**?  **If yes** please state: | |  |  |
| Has the baby had IM **Vitamin K**? | |  |  |
| Has the baby had ORAL **Vitamin K**? | |  |  |
| Is the baby **no more than TEN weeks** from its expected date of delivery (EDD)?  **If yes** please refer to Mr Patil, Ipswich, via GP | |  |  |
| Is this the first time the baby has been seen by ANY tongue tie service? | |  |  |
| **Informed the parents of the following-** | | | |
| They will receive an **email** with an appointment date and time within 7-10 days of receiving the referral. Contact will be by **EMAIL ONLY.**  **Advise parents to check their junk email.**  The email will detail:   * Where the clinic is to be held. * Date and time of appointment * Provide details of precautions taken during Covid pandemic * Advise only 1 parent can attend the appointment * Masks are to be worn during the appointment (these can be supplied at the time of the appointment) | | | |
| **N.B.**  During the appointment the feeding and tongue function will be assessed. A frenulotomy **MAY/MAYNOT** be offered dependant on the results of the assessment process. | | | |
|  | | | |
| Name of referrer: (PRINT) Job Title: | | | |
| Date of referral: | | | |
| Referrer contact details: |  | | |

**Please check you have filled in all the above details in otherwise this will result in the referral being rejected.**

**Thank you**

**From the Tongue Tie Team**