REFERRAL FORM FOR TONGUE TIE ASSESSMENT CLINIC

To be completed and emailed by a health professional to [tonguetie.assessment@nhs.net](mailto:tonguetie.assessment@nhs.net)

Clinic contact number 01384 456111 ext. 3887

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| **Baby’s Name:** |  | **Parental/Guardian’s Name:** |
| **Baby’s Unit/NHS Number:** | **Baby’s Gender:** |
| **Baby’s Date of Birth:** | **Baby’s Ethnicity** |
| **Baby’s Address** | **Name of Baby’s General Practitioner/Address** |
| **Baby’s Expected Date of Delivery (EDD)** |  | **Baby’s age at referral:** |
| **Parent/Guardians Preferred Contact Number:** | | |
| **Parent/Guardians Email Address:** | | |

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| **REASON FOR REFERRAL (delete as appropriate)** | |
| * Breast Feeding Issue - Formula Feeding Issue | |
| Further Details  **Has feeding support been accessed YES/NO**  ***NB: Only refer after feeding support has been accessed. Referrals for ‘future’ potential problems e.g. speech difficulties will not be accepted*** | |
| **DETAILS OF REFERRER: (delete as appropriate)** | |
| Midwife  General Practitioner  Health Visitor | Infant Feeding Specialist  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Name of Referrer: (PRINT)** | |
| **Referral Date:** | |
| **Referrer Contact Address** | **Referrer Contact Number** |

CHECKLIST FOR THOSE COMPLETING THE REFERRAL FORM FOR TONGUE TIE ASSESSMENT CLINIC – COMPLETE ALL BOXES

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| **PLEASE ANSWER ALL QUESTIONS** | **RESPONSES** |
| Are there any clotting disorders in close family members?  If yes please provide details. |  |
| Has the baby had a vitamin K injection or 2 doses of oral Vitamin K? |  |
| Does the baby have any follow up appointments other than routine appointments? Please provide details.  If the baby has any appointments relating to cardiac or neurological conditions written documentation stating a tongue tie division can be performed will be required from the baby’s consultant before an appointment can be offered. This will need to be co-ordinated by the referring Health Professional. |  |
| Ensure the baby is no more than eight weeks of age from the Expected Date of Delivery (EDD) e.g. a baby born at 32 weeks gestation could be referred up to 16 weeks old**.** Do not continue with this referral if the baby is over 8 weeks. For older babies refer the parents/guardian to the Association of Tongue Tie practitioners, a list of local practitioners can be found at: [**http://www.tongue-tie.org.uk**](http://www.tongue-tie.org.uk)**,** their GP or an ENT specialist |  |
| If this is a secondary referral provide details of any previous care or procedure. |  |
| This referral will first involve a telephone call during this a tongue tie clinic appointment may be offered. At the clinic appointment tongue function will be assessed and a division may be offered and performed if the parent/guardian consents. |  |
| Advise that a tongue tie practitioner will contact them within one week of receiving the referral. The number will be displayed as a withheld or no caller ID. Three attempts will be made to contact the parents and a failed call letter will be sent if no telephone contact is made and the referral will be cancelled. |  |
| Advise the parent/guardian to read the leaflet entitled ‘Tongue-tie’ which is available on the DGFT website: <http://www.dgft.nhs.uk/services-and-wards/maternity/maternity-information-leaflets/> |  |