REFERRAL FORM FOR TONGUE TIE ASSESSMENT CLINIC

|  |  |  |
| --- | --- | --- |
| **Baby Name:** |  | **Parental/Guardian Name:** |
| **Baby Unit Number (if available)** | **Baby’s Gender** |
| **Baby 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:** | | |

|  |  |
| --- | --- |
| **REASON FOR REFERRAL (delete as appropriate)** | |
| * Breast Feeding Issue - Formula Feeding Issue | |
| Other Reason: (Provide explanation)  ***NB: Referrals for ‘future’ potential problems e.g. speech difficulties will not be accepted*** | |
| **DETAILS OF REFERRER: (delete as appropriate)** | |
| Breastfeeding Buddy  Community Midwife  General Practitioner  Health Visitor  Hospital Midwife | Infant Feeding Specialist  Midwife  Self Referral  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

|  |  |
| --- | --- |
| **ACTION** | **Enter a YES for completion or enter N/A** |
| Ensure the parents have no heredity clotting disorders |  |
| Ensure the baby’s age is no more than ten weeks from its Expected Date of Delivery(EDD) e.g. a baby born at 32 weeks gestation could be up to 18 weeks old  **NB:** Do not continue with this referral if: babies are over 10 weeks (referring to above) then 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/index.html**](http://www.tongue-tie.org.uk/index.html)**,** their GP or an ENT specialist |  |
| Ensure the referral is to address a CURRENT feeding problem, referrals for potential future problems are not accepted |  |
| Ensure this is a **NEW** referral and care/procedure has not been provided previously/currently by another hospital or tongue tie practitioner.  Secondary referral is only accepted from a GP or another NHS Trust, in this case provide details of any previous care/procedure. |  |
| Explain that this referral will first involve a telephone consultation, following this an assessment tongue tie clinic appointment **MAY** be offered. At the clinic feeding will be assessed and **may be** offered and performed. Further breast feeding support **may** also be provided. |  |
| Ensure that you have provided the parent/guardian’s preferred contact number (on the front sheet). Advise that a tongue tie practitioner will contact them within a week of receiving referral. Make the parents aware of the tongue tie e-mail address for any non urgent queries: [**tonguetie.assessment@nhs.net**](mailto:tonguetie.assessment@nhs.net) |  |
| Advise the parent/guardian to read the leaflet entitled ‘Tongue Tie’ which is available on the DGH website:  [**http://www.dgh.nhs.uk/services/wards/maternity-unit-46/**](http://www.dgh.nhs.uk/services/wards/maternity-unit-46/)  For those who do not have internet access please issue with tongue tie leaflet whenever possible. |  |
| **Print Name:**  **Signature:** | **Date:** |