**Please complete this form (2 pages) and email to:** [**CSH.Referrals@nhs.net**](mailto:CSH.Referrals@nhs.net) **(preferred option)**

**or Fax: 0208 394 3863**

**PLEASE OBSERVE THE REFERRAL CRITERIA**

**The service is for babies over 11 days of age and registered with a Surrey GP.**

**Please note that babies registered with a Surrey Downs CCG GP can be seen at a younger age.**

This service is a frenulotomy service for babies who are identified with a tongue tie after 11 days of age and whose tongue tie is interfering with the baby’s ability to breast feed. The service is aimed primarily at babies for whom breastfeeding is the method of choice.

If there are parental concerns regarding the impact of a tongue-tie on future speech, dentition or the introduction of solid foods, advice should be sought from the General Practitioner to discuss a hospital referral.

**Area referred from:** CSH Surrey / First Community Health / Virgin Care

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Baby’s name:** | | **Date of birth:**  **Age of baby:** | | **Place of birth:** |
| **Address:** | | | | |
| **Tel Home:**  **Tel Mobile:** | **Date of referral:** | | **NHS Number:** | |
| **General Practitioner & Surgery:** | | | | |

|  |  |  |
| --- | --- | --- |
| **Name of referrer:** | | **Designation** |
| **Email address:** | | **Phone no:** |
| **Name of Infant Feeding Lead:**  ***(If known)*** |  | |
| **Name of Health Visitor:**  ***(If known)*** |  | |

**Referrer should take a full history and observe a feed**

**Assessment**

* Observe baby’s ability to extend tongue beyond lower gum ridge
* Observe suck pattern of feeding
* Observe baby’s ability to hold and maintain breast in mouth
* Observe maternal comfort during a feed
* Observe infant’s feeding and general wellbeing i.e. wet nappies /bowels open

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Baby** | **Yes** | **No** |  | **Mother** | **Yes** | **No** |
| Difficulty in latching |  |  | Squashed/wedged nipple |  |  |
| Clicking noises whilst feeding |  |  | Nipple pain during feed |  |  |
| Fussiness at breast |  |  | Sore damaged nipples |  |  |
| Prolonged/frequent feeding |  |  | Mastitis/breast infections |  |  |
| Prolonged physiological jaundice |  |  | Exhaustion from frequent feeds |  |  |
| Frequently coming of the breast or slipping back to the nipple |  |  | Psychological effects from difficulty in establishing breastfeeding |  |  |
| Excessive early weight loss/gain  Please specify |  |  | Family history of blood/ clotting disorders |  |  |
| Has Vitamin K been given |  |  |  |  |  |  |

**Any additional information (to be completed by referrer)**

|  |
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| --- | --- | --- | --- |
| **Ethnicity – Please Tick** |  | J.   Pakistani |  |
| A.   White – British |  | K.   Bangladeshi |  |
| B.   White – Irish |  | L.   Any other Asian Background |  |
| C.   White – Other |  | M.  Caribbean |  |
| D.   Mixed – White and Black Caribbean |  | N.   African |  |
| E.   Mixed – White and Black African |  | P.   Any other Black Background |  |
| F.   Mixed – White and Asian |  | R.  Chinese |  |
| G.  Mixed – And others |  | S.  Any other Ethnic Group |  |
| H.   Indian |  | Z.  Not stated |  |

|  |
| --- |
| **Date referral forwarded to CSH Surrey:** |

**Referrer will need to confirm that a history assessment and observation has taken place**

**Referral confirms appointment with parent**

**Record in RIO and PHCR**

**If feeding is improved by adjustments with Positioning and Attachment referral is no longer required.**

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