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REFERRAL FORM FOR INFANT (UNDER AGE 1) FRENECTOMY

Please return form to us by email

Today's date:_____ Examination date: _____

Referred from (provider): _____ Specialty/field: _____

Referral address: _____

Referral phone number: _____ Referral email: _____

Patient's name: _____ DOB: _____

Parent(s) or guardian: _____

Patient address: _____

Contact phone number and name: _____

Should we contact the patient? ☐ Yes ☐ No

Reason for referral (check all that apply):
☐ Evaluation and report only
☐ Evaluation and treatment as needed
☐ Lingual (tongue) frenectomy
☐ Labial (lip) frenectomy
  ☐ Maxillary
  ☐ Mandibular
☐ Buccal (cheek) frenectomy
  Location(s) (UR/LR/UL/LL): _____

Family history of lip/tongue-tie? ☐ Yes ☐ No

Has the baby had any of the following? (If so, referral to OT/PT may be recommended after the evaluation but prior to treatment):

☐ signs of aspiration (choking, coughing, respiratory infections, fevers, tearing of eyes, color change)
☐ underlying neuromuscular issue or medical diagnosis (e.g., down syndrome, cleft, seizure, etc.)
☐ oral aversion (extensive gagging, combative at sight, touch or smells near mouth)
☐ torticollis (twisted neck)
☐ plagiocephaly (flat head)

Baby's signs/symptoms:
☐ poor latch
☐ falls asleep while attempting to nurse
☐ slides off the nipple when attempting to latch
☐ colic symptoms
☐ reflux symptoms (spitting up, vomiting, stuffy nose)
☐ poor weight gain
☐ gumming or chewing of nipple when nursing
☐ unable to hold a pacifier in his or her mouth
☐ mouth breathing/open mouth resting posture
☐ snoring/noisy breathing
☐ short sleep episodes requiring feeding every 2-3 hours

Mother's signs/symptoms:
☐ creased/flattened/blanched nipples after nursing
☐ cracked/bruised/blistered nipples
☐ bleeding nipples
☐ severe pain when infant attempts to latch
☐ poor/incomplete breast drainage
☐ infected nipples or breasts
☐ plugged ducts
☐ mastitis or nipple thrush

Additional notes or concerns: