National Tongue Tie referral form

To be completed by referee:

Patient details:

Date :

Name: Surname: Mothers Name: Contact Phone:
DOB:
Male ☐ Female ☐
Place of birth:
Birth Weight: Current Weight:

Lactation Consultant:

Reason for referral:

Maternal issues:	Infant Issues:
Nipple pain ☐	Can't latch ☐
Ulceration ☐	Can't maintain latch ☐
Mastitis (current or previous) ☐	Aerophagia ☐
Poor Supply ☐	Colic/ Reflux ☐

Feeding:

Exclusive BF ☐
Pumping ☐
Using shields ☐
Supplementation with formula ☐ % of feeds non BF
Exclusive formula feeding ☐

Tongue functionality/ restriction:

Lateralisation ☐ Elevation ☐

Oral anatomy:Normal

Ankyloglossia:

Anterior ☐ Posterior ☐ Comment

Referring practitioner:

Consultant ☐ GP ☐ IBCLC ☐ Other ☐
Name
Contact Phone Number

Please note surgical intervention is only provided when there are established or predicted functional impacts of ankyloglossia.