

Consultant Paediatric Surgeon

Evelina Childrens Hospital

Lambeth Palace Rd

London SE1 7EH

Dear tongue tie clinic,

Referral for division of a tongue tie

**Date of referral:**

**Baby’s name:**

**Parent’s name:**

**Seen and assessed by:**

**On:**

**At:**

**Referrer’s contact details including phone number:**

**Baby’s DOB:**

**Baby’s Hosp No:**

**Baby’s NHS number (if not born at GSTT):**

**Age at assessments:**

**Type of birth:**

**Place of birth:**

**Complications or medical problems:**

**Birth weight:**

**Adequate weight gain:**

**Number and colour of stools per day**:

**Adequate wet nappies:**

**Vitamin K:**

**Jaundice:**

**Type of tongue tie:**

**Main Issues :**

**Length of feeds:**

**Frequency of feeds:**

**Thrush:**

**Engorgement/mastitis/blocked ducts:**

**Feeding positions and attachment:**

**Nipple damage**

**Pain:**

**Nipple shape after feeds:**

**Supplements:**

**Feeding methods:**

**Expressing:**

**Plan:**

**Address:**

**GP:**

**Parent’s Phone number:**

Send completed referral to gst-tr.EvelinaTongueTieClinic@nhs.net