

**Checklist and information for Evelina Tongue Tie Clinic.**

**Please read before completing the referral form.**

For the sake of efficiency/clarity please do not hand write or scan this form.

Referrals will only be accepted under the following criteria:

-Identified tongue tie that is causing a feeding issue.

-Unresolved feeding issues despite best practice support.

-Please note we do not accept referrals on the basis of perceived future issues e.g. speech difficulties.

- We do not assess or divide lip ties as there is no current evidence to suggest that division will improve breastfeeding.

GSTT babies will be seen as a priority. Out of area referrals will be offered an appointment as soon as possible, however you may wish to consider local NHS facilities. N.B. Please make it clear to parents that they will receive a phone call from the tongue tie clinic offering them the next available appointment and harassing the staff is likely to lead to a refusal rather than quicker appointment. This clinic will not see babies over 12 weeks of corrected age. Should you need a referral for an older baby, please contact your local ENT surgery department via the GP.

This clinic is not an assessment clinic, therefore all babies referred must have had at least two full face to face breastfeeding assessment prior to referral. They should receive consistent breastfeeding support prior to and post-procedure. No routine follow up is arranged at Evelina and no follow up call will be made. In the case of re-adhesions, please label as urgent.

It should be made clear to the parents that they are not coming for assessment of the tongue tie/breast feeding but for a division of a tongue tie if affecting feeds. Parents must be committed to breast feeding. If they have stopped breast feeding completely andhave no intention to breast feed they should not be referred to the clinic. The Tongue division would not be done even if they come to the clinic.

Tongue tie is assessed by function as well as appearance, therefore please complete all sections of the referral form as it is important to have a full assessment documented.The following points should be read in conjunction with the referral form.

1. Please ensure you have made an assessment of mum’s milk supply, differentiating between those who need to supplement to maintain their baby’s wellbeing and those who perceive or have been told they have an inadequate supply. Please inform us of what measures have you put in place to maintain/increase supply. Please note clicking alone is not a sign of tongue tie, it is often related to high milk flow/positioning.
2. Lateralisation can be assessed by yourself if competent or able, or by the mother. Sweep the index finger across the floor of the mouth and note whether the tongue follows to the corner (lateralisation) or curls up (partial/poor).
3. Mothers and babies with tongue tie issues are sometimes diagnosed with Thrush as well. Often the signs and symptoms they are displaying can also be attributed to feeding difficulties. We often find that mothers who are attributing most of their issues to Thrush are either not able or willing to listen to the information we try to give them at the clinic that might improve their feeding, therefore please consider the following list with any dyad you think might have Thrush before making the diagnosis.

* Fussiness at the breast – consider poor positioning or low/oversupply.
* Breast/nipple pain-check positioning and attachment, engorgement/mastitis or ischaemic breast pain.
* White coating on tongue- milk deposit accumulation (baby’s lack of tongue movement impairs normal clearing).
* White/blanched nipples- has mum got/developed Reynaud’s Phenomenon or vasoconstriction due to poor positioning?
* History of vaginal thrush or antibiotic use-there is no evidence to suggest that these are linked to breast or nipple thrush.

Please refer to BFN information sheet for further information https://www.breastfeedingnetwork.org.uk/detailed-information/drugs-in-breastmilk/thrush-and-breastfeeding/

1. Although a midwife is present to support feeding, her time with each dyad is limited therefore it is vital mums are confident with positioning and recognising effective attachment as we promote prompt feeding post procedure to allow healing and comfort. Therefore, it is important that we are aware of the tool you have used (e.g. CHINS, Close, Head free, In line, Nose to nipple, Sustainable) so we can use the same with the mum.
2. Bottle feeds affected- We do not consider any feeds less than 40 mins as prolonged. Are parents aware that some dribbling and wind is extremely common in bottle fed infants? Parents must be informed of paced/responsive bottle feeding. Babies can become overwhelmed with fast flow/inappropriate teat flow and shape. A thorough bottle feeding assessment is just as important as a breastfeeding assessment! Please note we do not have the appropriate facilities to prepare powdered formula.

Lastly please ensure that all parents have access to the Patient Information Leaflet as this gives information about what to expect in the tongue tie clinic.

https://www.evelinalondon.nhs.uk/resources/patient-information/correcting-your-babys-tongue-tie.pdf

Please email to [gst-tr.EvelinaTongueTieClinic@nhs.net](mailto:gst-tr.EvelinaTongueTieClinic@nhs.net)

 Referral for Tongue Tie Clinic.

**Please note you need to complete this form and the checklist. If neither is filled then unfortunately we will not be able to consider your referral.**

**Parental details:**

|  |  |
| --- | --- |
| **Parent’s name:** | **Alternative contact number:** |
| **Address:** | **GP Address** |
| **Mothers Contact number:** | **Email address if available:** |

|  |  |
| --- | --- |
| Baby’s name: | Baby’s DOB: |
| Baby’s Hosp No/NHS no: | **Hospital/borough of Birth:** |
| **Type of birth:** | **Complications or medical problems in mother or baby :( State issues)** |
| **Gender:** | **Birth weight and current weight if different:** |
| Dates and age at assessments(last one needs to have been within the last working week) | **Vitamin K route- (IM or 3 oral doses needs to be given, or baby is required to have a clotting screen if baby is under 4 weeks old) :** |

**Referrer’s details:**

|  |  |
| --- | --- |
| Name: | Job role: |
| Level of experience in assessing tongue ties: | Trust/location: |
| Telephone number: | Email Address: |
| **Where did assessments take place? Venue-please name group:** | **Provision for follow up care:** |

**Referral and plans:**

|  |  |  |
| --- | --- | --- |
| **What are your reasons for referral?**  Nb. If bottle feeding, see point 5 in checklist for prompts on bottle feeding assessment. |  | |
| **Method/s of feeding** |  | |
| **Sore/cracked nipples** | Yes | No |
| **Low/inadequate supply**  See point 1 in checklist. | Yes, please comment: | No |
| **Engorgement/blocked ducts** | Yes | No |
| **Infected mastitis** | Yes | No |
| **Painful feeds** | Yes, please comment: | No |
| **Sleepy during feeds** | Yes | No |
| **Short feeds consistently less than 5 mins** | Yes | No |
| **Prolonged feeds consistently more than 45mins** | Yes | No |
| **Age appropriate output** | Yes | No |
| **Frequency of feeds** | Please comment: |  |
| **Frenulum visible** | Yes | No |
| **Tongue extension** | Yes | Partial/poor |
| **Tongue elevation** | Yes | Partial/poor |
| **Tongue lateralisation**  See point 2 in checklist. | Yes | Partial/poor |
| **Diagnosed Thrush**  See point 3 in checklist. | Yes | No |
| **Any other information** | Please comment: | |

|  |  |  |
| --- | --- | --- |
| **Action taken to maintain breastfeeding and or supply, if no please implement the following.** | Yes | to be implemented/comments |
| Please attach any plan you have made or fill in below. |  | |
| **Skin to skin** |  |  |
| **Breast familiarisation** |  |  |
| **Breastfeeding attachment and positioning tool e.g. chins**  See point 4 in checklist. |  |  |
| **Positions tried and preferred** |  |  |
| **Expressing 8-12x in 24 hours** |  |  |
| **Supplementation/method** |  |  |

**Referrals for re-adhesions**

|  |  |
| --- | --- |
| **Date of initial division** |  |
| **Surgeon if known** |  |
| **Evelina or other, please state:** |  |
| **Assessment of tongue appearance and movement** |  |
| **Was there an improvement in feeding issues after the initial division?** |  |
| **Describe current feeding issues.** |  |