

# Tongue Tie Referral Form

Submit referral via email with subject header "TT referral & baby's name":

Chelwest site: [caw-tr.tonguetie@nhs.net](mailto:caw-tr.tonguetie@nhs.net)

West Mid site: [TongueTie.WMUH@nhs.net](mailto:TongueTie.WMUH@nhs.net)



Baby's Details	Mother's Contact Details
Today's Date:	Mother's name:
Baby's Name:	Mother's email (required):
Baby's DOB:	Contact number:
Baby's sex:	
Place of birth:	
Baby's CW Hospital No:	
NHS no (if not born at CW):	

Infant Feeding Assessment (tick all that apply)	Mother's Assessment (tick all that apply)
Gestation at birth:	Nipple pain <input type="checkbox"/>
Bottle feeds lasting more 40 min <input type="checkbox"/>	Nipple trauma <input type="checkbox"/>
Breastfeeds consistently more than 40 min <input type="checkbox"/>	Mastitis/recurrent mastitis <input type="checkbox"/>
Unable to sustain latch <input type="checkbox"/>	Thrush symptoms <input type="checkbox"/>
Excessive wind/colic symptoms <input type="checkbox"/>	Early postnatal engorgement <input type="checkbox"/>
Milk/saliva dribble <input type="checkbox"/>	Low milk supply <input type="checkbox"/>
Jaundice <input type="checkbox"/>	<b>Baby's relevant history</b>
Weight loss or slow/static weight gain <input type="checkbox"/>	Family history of bleeding disorders <input type="checkbox"/>
Clicking during feeds <input type="checkbox"/>	Vitamin K given IM <input type="checkbox"/>
Falls asleep at the breast <input type="checkbox"/>	Vitamin K given Oral 2 <sup>nd</sup> dose <input type="checkbox"/>
	Newborn bloodspot screening taken <input type="checkbox"/>
	Excessive bleeding at NBBS <input type="checkbox"/>
	<b>Please do not refer a baby who has not had vitamin K. Second oral dose can be given at 4-7 days of age.</b>

Suggested Feeding Plan
<i>We strongly encourage the following suggestions, please tick all the mother has practiced:</i>
Extended skin to skin <input type="checkbox"/>
Baby led positioning & self-attachment taught <input type="checkbox"/>
Laid back positions (biological nurturing) <input type="checkbox"/>
Principles of C.H.I.N. in place <input type="checkbox"/>
Maintain 8-12 feeds in 24hrs <input type="checkbox"/>
Express to protect supply <input type="checkbox"/>
Breast compressions <input type="checkbox"/>
Switch breastfeeding <input type="checkbox"/>
<b>Further comments to support your referral:</b>

Referrer's details & confirmation
<input type="checkbox"/> I confirm that positioning and attachment have been observed at least on 2 occasions, and corrected as needed.
<input type="checkbox"/> Baby is/may be an inpatient so discussed with neonatal consultant.
Name: _____ Job title: _____
Place of work (trust/team): _____
Tel: _____ Email: _____