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Department of Paediatric Surgery

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| Tongue-tie Service referral form | | | |
| **Important:**   * As of the 11th February 2025 we will only accept referrals for babies born at one of the King’s College Hospital NHS Trust sites (King’s College Hospital, Denmark Hill and Princess Royal University Hospital) * The service will only accept referrals for babies up to 4 months of age and will not be able to accept or perform recurrence procedures. * We only accept referrals from NHS Breastfeeding Specialists (i.e. Lactation Consultant, Infant Feeding Advisor and Breastfeeding Counsellor). * GP / Hospital consultant referrals only accepted with feeding assessment from breastfeeding specialist (as named above). * Non-NHS referrals must be accompanied by a supporting GP referral to ensure funding for the procedure. * We try to see properly worked up referrals in our next available clinic. Incomplete referrals will result in a delay. * Where possible please complete this referral electronically and submit via email. * . | | | |
| **About the patient (baby)** | | | |
| NHS Number |  | KCH Hosp. ID |  |
| Baby’s name |  | | |
| Date of birth |  | Baby’s gender |  |
| Place of Birth |  | | |
| GP name/ address/ email address |  | | |
| **About the parent(s)** | | | |
| Full names of baby’s parent(s) |  | | |
| Postal address |  | | |
| Postcode |  | | |
| Phone number |  | | |
| Is an interpreter required?  Yes  No | If yes, specify language: | | |
| **Referrer’s Information** | | | |
| Referrer’s full name |  | | |
| Referrer’s job title |  | | |
| Name of referrer’s NHS commissioning organisation / postal address |  | | |
| Referrer’s email address |  | | |
| Referrer’s phone number |  | | |

Please provide the following information about the patient:

|  |  |  |  |
| --- | --- | --- | --- |
| 1. Has baby had frenulotomy performed previously? | Yes  No | | |
| 1. If yes, how many times has frenulotomy been performed previously? *Please give details; dates of procedures, any initial improvement etc.* |  | | |
| 1. Baby’s age at time of referral? (incl. corrected age for pre-term babies) | days/weeks | | |
| 1. Has baby received vitamin K prophylaxis? | Oral | IM injection | No |
| Doses given? |
| 1. Are there any other significant medical problems?   *Please give details. If baby is being supported by e.g. cardiology team, we would need consent from the team before going ahead* |  | | |

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| --- | --- | --- | --- |
| 1. Date of first feeding assessment: \_\_\_\_\_\_\_\_\_\_\_   *Note: Babies need to have been assessed by a Breastfeeding Specialist with observation of feed and initial feeding plan made and subsequent review of that plan.*  *(Please see referral checklist on page 4 for further details.)* | | | |
| 1. Has a breastfeed been observed? | Yes | | No |
| 1. What plan was put in place to initiate and maintain breastfeeding?   *(Please tick as many options that apply)* |  | Advice on positioning and attachment | |
|  | Plan to increase milk supply Galactagogue food / medication and or pumping | |
|  | Supplementation with formula advice | |
|  | Supplementation with expressed breast milk advice | |
|  | Importance of skin to skin | |
|  | Nutritive and non-nutritive sucking | |
|  | Breast compressions | |
| 1. Is baby using nipple shields? | Yes | | No |
| 1. Are there any supplemental feeds? | Yes | | No |
| 1. Please detail both Volume and number of expressed breast milk feeds: | mls per feed | | Number of supplemented feeds per 24 hrs |
| 1. Please detail both volume and of number of formula feeds per day? | mls per feed | | Number of supplemented feeds per 24 hrs |
| 1. Method of supplementation   *Please consider use of SNS/finger feeding in order to minimise bottle use as much as possible ahead of referral.* |  | Bottle | |
|  | Finger Feeding | |
|  | SNS | |
| Other: | | |
| 1. List other key difficulties in breast feeding: |  | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. Date of second assessment/review: \_\_\_\_\_\_\_\_\_\_\_   *Note: a face-to-face (not by telephone) review of feeding plan with observation of a feed within 5-7 days before referral is preferred. Include details of how the feeding plan / interventions have assisted breastfeeding or not. Attach copies of your feeding/treatment plan and details of the outcome of its review.* | | | | |
| 1. Please provide baby’s last known weight at time of referral: | \_\_\_\_\_\_\_\_\_kg | | | |
| 1. What plan is now in place to maintain breastfeeding?   *(Please tick as many options that apply)* |  | Advice on positioning and attachment | | |
|  | Plan to maintain milk supply Galactagogue food / medication and or pumping | | |
|  | Supplementation with expressed breast milk advice | | |
|  | Importance of skin to skin | | |
|  | Nutritive and non-nutritive sucking | | |
|  | Breast compressions | | |
| 1. Has formula supplementation been reduced? | Yes | | No | N/A |
| 1. Please detail both Volume and number of expressed breast milk feeds: | mls per feed | | Number of supplemented feeds per 24 hrs | |
| 1. Please detail both Volume and frequency of formula feeds: | mls per feed | | Number of supplemented feeds per 24 hrs | |
| 1. Method of supplementation   *Please consider use of SNS/finger feeding in order to minimise bottle use as much as possible ahead of referral.* |  | Bottle | | |
|  | Finger Feeding | | |
|  | SNS | | |
| Other: | | | |
| 1. What steps have been taken to maintain or increase milk supply? |  | | | |
| 1. Has milk supply increased? | Yes | | No | N/A |
| 1. How many times does baby go to the breast per day? *(Please see important note on the last page of this form for further details).* |  | 0-3 times in 24 hours | | |
|  | 4-9 times in 24 hours | | |
|  | 10+ times in 24 hours | | |
| 1. List other key difficulties that are still present in breast feeding: |  | | | |
| 1. Is parent intending to continue breastfeeding? Please also give details of any relevant family history e.g. siblings with tongue tie/ previous breastfeeding experience | Yes | | No | |
| 1. Description of tongue tie: |  | | Anterior (visible) | |
|  | | Posterior | |
| 1. Details of tongue mobility observations: |  | | | |

**\*\*Important**

There is a high demand for appointments. Priority will be given to referrals that meet the criteria. To ensure frenulotomy-readiness parents should be supported to offer babies a breastfeed for every feed. Formula supplements should be less than 50% of total daily requirement. This will assist quick progression after frenulotomy.

Babies cannot be referred to the Tongue-tie Clinic for speech concerns.

**Post-frenulotomy**

We do not offer post-operative follow-ups in our clinic, therefore parents will be asked to contact their local infant feeding service/breastfeeding support group once an appointment has been confirmed with the Tongue Tie Clinic. This is to arrange follow-ups at 5-7 and 10-14 days following a frenulotomy, and receive adequate feeding support and evaluate progress.

***Sending your referral form***

Please email your completed form to [kch-tr.tonguetieclinic@nhs.net](mailto:kch-tr.tonguetieclinic@nhs.net)

Your referral will be reviewed by one of the Tongue-tie Clinic Lactation Consultants. In case of babies with a complex medical history, Mr Niyogi will also be consulted.