Charlottesville Pediatric Dentistry

Patient Name_____ Date of Birth_____ SNN_____
Parent Name_____ Pediatrician _____
Lactation Consultant _____ Who referred you? _____
Is your infant being seen for bodywork (chiropractor, physical therapist, osteopath, occupational therapist, other)?
If Yes, what type and by whom_____

MEDICAL HISTORY

Birth weight_____**lbs/oz** Current weight_____**lbs/oz**
Food Allergies **Yes** **No** if yes, which foods _____
Medication Allergies **Yes** **No** if yes, which medications_____
Is there a family history of bleeding disorders? **Yes** **No**
Has your child received a Vitamin K shot? **Yes** **No**
List ALL current maternal medications/supplements _____
List ALL current infant medications/supplements _____
Was your infant premature **Yes** **No** If yes, gestational age at birth _____
Does your infant have any heart disease **Yes** **No**
Has your infant had any surgeries **Yes** **No**
If yes, what type(s) and when_____
Has your infant had prior surgery to correct the tongue or lip tie? **Yes** **No**
If yes, what type(s) and where _____
Does your child have any other medical conditions **Yes** **No**
If yes, please explain _____
Is there a family history of a tongue or lip tie **Yes** **No** **who?** _____

PREGNANCY/LABOR HISTORY **Normal or High Risk (please circle)**

Were there any stressors with labor? **Yes** **No**
Please Circle **Long labor/Excessive pushing Breech BirthUnplanned C-section Vacuum/Forceps Trauma other**
(please explain) _____ Difficulty with latch after birth? **Yes** **No**
If yes, please explain _____

FEEDING HISTORY

Is this your first time breastfeeding? **Yes** **No** if no, how many children for how long?
Are you supplementing with pumped breast milk **Yes** **No** How many bottles/oz per day_____
Are you supplementing with formula **Yes** **No** How many bottles/oz per day? _____
Are you using SNS or any other supplementer? **Yes** **No**
Are you currently using nipple shields? **Yes** **No**
How do you rank your milk supply? **Oversupply** **Good** **Fair** **Poor**
How many times do you feed per day? _____
On average, how long does it take to feed your child? _____Mins
Have you done any pre and post feeding weight checks? **Yes** **No**
How much was transferred? _____

BABY'S SYMPTOMS

Does your infant have a history of poor weight gain?	**Yes**	**No**
Does your infant struggle to stay awake while feeding?	**Yes**	**No**
Does your infant struggle to get a good latch while feeding?	**Yes**	**No**
Does your infant's upper lip remain tucked in while feeding?	**Yes**	**No**
Does milk or formula leak out of the corners of mouth or nose while feeding?	**Yes**	**No**
Do you hear a "clicking" noise while your baby feeds?	**Yes**	**No**
Does your infant chomp and gum your nipples while feeding?	**Yes**	**No**
Does your infant become fussy at the breast or bottle?	**Yes**	**No**
Is your infant gassy?	**Yes**	**No**
Does your infant frequently burp or hiccup?	**Yes**	**No**
Does your infant cough or choke during or after feeding?	**Yes**	**No**
Has your infant been diagnosed with GERD (reflux)?	**Yes**	**No**
If yes, list medications _____		
Does your infant have a distended or bloated belly after feeding?	**Yes**	**No**
Is your infant experiencing Colic?	**Yes**	**No**
Does your infant use a pacifier?	**Yes**	**No**
If yes, does it frequently fall out?	**Yes**	**No**
Is your infant resistive and stressed when placed in the car seat?	**Yes**	**No**

MOTHER'S SYMPTOMS

Please rate your level of discomfort while feeding (1- no pain, 10- extreme pain)

1 2 3 4 5 6 7 8 9 10

Do you have clogged ducts?	**Yes**	**No**
Do you have a history of, or currently have, Mastitis?	**Yes**	**No**
Do you have a history of, or currently have, nipple/infant thrush?	**Yes**	**No**

Please circle any of the following regarding your nipples after feeding

creased flattened lipstick shaped blanching cracked bruised
bleeding blistered normal

Please share your feeding goals and any other concerns

_____

I agree that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform Charlottesville Pediatric Dentistry of any changes to my information and my child's medical status.

_____

Parent Signature Date

INFORMED CONSENT

The **lingual frenectomy/frenotomy** is a minor surgical procedure that involves clipping and/or lasering the band of tissue located on the underside of the tongue (frenum or frenulum). When this band is too tight, too short, or both, normal tongue movement is prevented.

The treatment may accomplish the following, but not be limited to:

- Allow the tongue to move in greater range of motion
- Possibly improve breastfeeding comfort
- Possibly improve breastfeeding efficiency
- Possibly reduce the severity of speech difficulties

Complications of this treatment may include, but not be limited to:

- Excessive bleeding
- Damage to the vital structures under the tongue
- No perceivable benefit may be achieved

The **labial frenectomy/frenotomy** is a minor surgical procedure to free the lip attachment from the gums when it is too tight and/or too short. It can restrict proper lip movement and flexibility.

The treatment may accomplish the following, but not be limited to:

- Allow adequate lip flange to improve nursing effectiveness
- Reduce the pockets on either side of the frenum to prevent food trapping
- Give the upper lip more freedom of movement for speech sounds
- Possible reduction in reflux/aerophagia

Complications of this treatment may include, but not be limited to:

- Excessive bleeding
- Lip muscle damage
- No perceivable benefit may be achieved

Please not that treatment is NOT intended to prevent a gap between the upper front teeth. If that is the goal, it may need treatment at about 7-8 years of age

Please note that outcomes are vastly dependent upon your completion of stretches. If stretches are not done adequately then undesired scaring will occur and can inhibit the function of the tongue/lip and decrease success.

This consent is not binding. It is to inform you of the pros and cons of treatment. By signing this consent, you are <u>not</u> committing to treatment.

_____ I understand the pros/cons and risks/benefits of treatment.

Signature: _____ Date: _____