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## Frenectomy Referral

Patient Name

Patient DOB

Date

Guardian Name

Phone Number

### Reason for Referral (must select one)

- ☐ Labial (Lip) Frenectomy
- ☐ Lingual (Tongue) Frenectomy

### Functional Limitations (must select one)

- ☐ Poor latch during breastfeeding
- ☐ Feeding/swallowing issues
- ☐ Symptomatic ankyloglossia has not improved with lactation support
- ☐ Speech difficulties

### Attempted Therapies That Have Failed (must select one)

- ☐ Lactation support
- ☐ Positioning adjustments
- ☐ Nipple support/protection
- ☐ Breast pumping/supplemental feeding support
- ☐ Maternal dietary/ pain management strategies
- ☐ Therapies for infant oral skills (non-surgical)

### Consultation Support Received (must select one)

- ☐ Myofunctional Therapist
- ☐ Speech Pathologist/Therapist
- ☐ Lactation consultant
- ☐ Chiropractor, ENT
- ☐ Other:

### Additional Notes/Observations

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### Attestation required for Medicaid patients

- ☐ I'm a primary care provider with expertise in caring for newborns and providing ongoing infant care that diagnoses symptomatic ankyloglossia that is not improving with lactation support or other measures and recommends frenectomy.

### Provider Signature

### Referring Provider Medical Specialty

- ☐ Pediatrician
- ☐ Nurse Practitioner
- ☐ Physicians Assistant

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