Infant Frenectomy Questionnaire

Patient's Name:_____ Patient's DOB:_____ Patient's age:_____ Sex:____
Today's Date: _____Parent's Name(s):_____ Primary Phone:_____
Address: _____City_____ State_____ Zip:_____
Email:_____
Pediatrician's Name: _____
Are you currently working with a lactation consultant? O**Yes** O**No**
If yes, who and when? _____
Is your child currently being seen for other services? (chiropractic care, physical therapy, occupational therapy, craniosacral therapy, speech therapy, feeding therapy, osteopathy etc.) O**Yes** O**No** If yes, what type? _____
If yes, why and by whom?_____
If yes, when/total number of visits?_____
Do you have any concerns with your child's gross motor development? (rolling, sitting, crawling, etc.).
_____
Does your child prefer turning or tilting his/her head? (in car seat stroller, while sleeping, etc.).
_____
Are you concerned with your baby's head shape? _____
Is this your first child? O **Yes** O **No** Family history of tongue tie? O**Yes** O**No**
Has Dr. Dabir treated you or a family member in the past? O**Yes** O**No** If so, who/when? _____
How did you hear about our office? _____
Please summarize your main concerns/reason for visit: _____

MEDICAL HISTORY

Birth weight (lb/oz): _____ Most current weight (lb/oz):_____
List all current maternal medications/supplements:_____
List all current child medications/supplements:_____
Does your child have any allergies? (Food, medication, etc.) O**Yes** O**No** If yes, please describe:_____
Does your child have any heart diseases? O**Yes** O**No** If yes, please describe: _____
Are your child's vaccines up to date? O**Yes** O**No**
Is there a family history of bleeding disorders? O**Yes** O**No**
Did your child receive Vitamin K injections? O**Yes** O**No**
Excessive bleeding after heel stick? O**Yes** O**No**
Has your child had any surgeries? O**Yes** O**No** If yes, what type(s) and when:_____
For Boys: Circumcision done? O**Yes** O**No** Any complications after the procedure? O**Yes** O**No**
Has your child had prior surgery to correct a tongue or lip tie? O**Yes** O**No**
If yes, what type(s) and where: _____
Does your child have any other medical conditions or health concerns? O**Yes** O**No**
If yes, please describe: _____

PREGNANCY/LABOR HISTORY: O **Normal** or O **High Risk** Birth Location: _____

Was your child premature? O**Yes** O**No** If yes, gestational age at birth: _____

Were there any additional stressors with labor? O**Yes** O**No**

Please select all that apply: O**Vaginal** birth O**Long labor** O**Unplanned C-section**

O**Excessive pushing** O**Trauma from vacuum or forceps** O**Planned C-section** O**Breech birth**

Other (please explain):_____

Difficulty with latch after birth? O**Yes** O**No**

During your pregnancy were you taking the following medications: (please circle if yes)

Phenobarbital, Phenytoin, and/or Carbamazepine? _____

MODE OF FEEDING

Please describe your current mode(s) of feeding: _____

Are you currently breastfeeding? O**Yes** O**No**

If yes, please select: O**Exclusively breastfeeding** O**Mix of breast/bottle feeding**

How would you rate your milk supply? O**Oversupply** O**Good** O**Fair** O**Poor**

Do you have a history of breast surgery? O**Yes** O**No**

Are you currently using a nipple shield? O**Yes** O**No**

Are you using an SNS? O**Yes** O**No**

Is this your first time breastfeeding? O**Yes** O**No** O**N/A** Other breastfed children/how long? _____

Are you currently bottle feeding? O**Yes** O**No** If yes, what type of bottles? _____

Are you supplementing with pumped breast milk? O**Yes** O**No** How many bottles/ounces per day? _____

Are you supplementing with formula? O**Yes** O**No** How many bottles/ounces per day? _____

Type of formula:_____

Does your baby use a pacifier? O**Yes** O**No**

Baby's Symptoms

Does your baby CONSISTENTLY fall asleep while attempting to nurse? O**Yes** O**No**

Does your baby CONSISTENTLY slide off breast when latching/feeding(Skip if N/A) O**Yes** O**No**

Does his/her upper lip CONSISTENTLY curl inward(does not flip out) when latched? O**Yes** O**No**

Does your baby CONSISTENTLY have his/her mouth open at rest? O**Yes** O**No**

Does milk or formula leak/spill out of mouth while feeding at breast/bottle O**Yes** O**No**

Does your baby CONSISTENTLY experience colic symptoms? O**Yes** O**No**

Does your baby CONSISTENTLY become visibly frustrated at the breast/bottle? O**Yes** O**No**

Does your baby CONSISTENTLY exhibit reflux symptoms? O**Yes** O**No**

Is your baby CONSISTENTLY extremely gassy? O**Yes** O**No**

Does your baby CONSISTENTLY snore during sleep? O**Yes** O**No**

Does your baby CONSISTENTLY exhibit noisy congested breathing? O**Yes** O**No**

Has your pediatrician noted slow or poor weight gain? O**Yes** O**No**

Have you done any pre and post feeding weight checks? O**Yes** O**No**

If so, what was the transfer rate: _____ ounces per _____ minutes

Does your baby CONSISTENTLY display gumming or chewing of your nipple while nursing? O**Yes** O**No**

Is there a CONSISTENT "clicking noise" while feeding? O**Yes** O**No**

Does your baby seem CONSISTENTLY dissatisfied after feeding sessions? O**Yes** O**No**

if not, please explain: _____

What is the average length of feeding time in minutes? O**less than 15** O**15-30** O**30-45** O**45-60** O**+60**

Sleeping

Does your child…

CONSISTENTLY sleep with an open mouth at night? O**Yes** O**No**

CONSISTENTLY sleep noisy/restlessly? O**Yes** O**No**

CONSISTENTLY sleep with a pacifier? O**Yes** O**No**

Does your child CONSISTENTLY wake up through the night? O**Yes** O**No**

if yes, how many times per night is child waking? _____

If yes, how many nights per week is his/her sleep affected? _____

Please describe your current sleeping arrangement O**Co-sleeping** O **In bassinet/crib**

Breathing

Does your child…

CONSISTENTLY rest in an open mouth posture during the day? O**Yes** O**No**

CONSISTENTLY mouth-breathes during the day? O**Yes** O**No**

CONSISTENTLY exhibit a forward head posture? O**Yes** O**No**

Please describe any other disturbances to eating, speaking, sleeping, breathing:

_____

Mother's Symptoms (If breastfeeding)

Please rate your level of discomfort while feeding: O**None** O**Very low** O**Medium** O**High** O**Very High**

Are your nipples becoming creased/flattened/lipstick-shaped/blanched white after nursing O**Yes** O**No**

If yes, please select: O**Right Side** O**Left Side** O**Both**

Are your nipples becoming cracked, bruised, or blistered after nursing? O**Yes** O**No**

If yes, please select: O**Right Side** O**Left Side** O**Both**

Are your nipples bleeding?

If yes, please select: O**Right Side** O**Left Side** O**Both**

Is there any severe pain when your baby attempts to latch?

If yes, please select: O**Right Side** O**Left Side** O**Both**

If yes, please select: O**Pain subsides after initial latch** O**Pain persists throughout feeding**
O**Pain is felt in between feeds**

Are you experiencing poor or incomplete breast drainage? O**Yes** O**No**
Do you have a history of, or currently have mastitis? O**Yes** O**No**
Do you have a history of, or currently have, nipple/baby oral thrush? O**Yes** O**No**

Child's Symptoms

Please fill out the following sections only if age-appropriate for your child

Eating Solid Foods

Does your child…

Show little interest in foods? O**Yes** O**No**
Hold food in his/her mouth for extended periods of time? O**Yes** O**No**
Swallow large chunks of partially chewed food? O**Yes** O**No**
Choke on solids or liquids? O**Yes** O**No**
Spit out food? O**Yes** O**No**
Have any digestive issues? O**Yes** O**No**
Spit up or throw up shortly after eating? O**Yes** O**No**

Speaking

Does your child have language or articulation difficulties or delays? O**Yes** O**No**

if yes, please describe: _____

Is your child currently seeing a speech pathologist? O**Yes** O**No**

CONCERNS & GOALS

In a sentence or two, please share your current feeding concerns:_____

_____

In a sentence or two, please share your feeding goals:_____

_____

Medical Information Release Form (HIPPA Release Form)

Name: _____ DOB: _____

Release of Information:

[ ] **I hereby authorize** Carlsbad Children's Dentistry and affiliates to release my child's health/treatment records to the individuals below.

*We typically release appointment reports to the providers listed.

Parent/Spouse/Relative _____

Referring Provider _____

Pediatrician _____

Lactation Consultant _____

Speech/Physical/Occupational Therapist _____;

Bodyworker/Doula/Midwife/Other _____

(Describe information not to be disclosed, If any)

[ ] I do not authorize Carlsbad Children's Dentistry or affiliates to release any medical information.

*This ***release of information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] My Home [ ] My Work [ ] My Cell # _____

If unable to reach me:

[ ] You may leave a detailed message

[ ] Please leave a message asking me to return your call

[ ] _____

The best time to reach me is (day) _____ between (time) _____

Signed: _____ Date: _____

Witness: _____ Date: _____

Infant and Baby Frenectomy Consent

Diagnosis:

After a careful oral examination of my child's mouth, Dr. Dabir has identified restrictive tension/shortened frenular tissue under the tongue (lingual frenulum), central upper lip (labial frenulum) or cheek areas (buccal frenula). The restrictive tissue may be related to symptoms experienced.

Such tethered oral tissues can limit function during breastfeeding or bottle-feeding, chewing and swallowing, articulation and can affect maxillofacial development, orofacial muscle tension, and sleep patterns.

Recommended Treatment:

In order to treat this condition, Dr. Dabir has recommended a frenectomy (a procedure to release the tight frenular tissue). A topical numbing gel will be applied to help anesthetize the tissue. The child will be swaddled and safety goggles will be placed. A CO2 laser will then be used to release the restrictive frenular tissue. Depending on the child's age, a bite block may be used to keep the mouth open during the procedure.

The treatment may help accomplish the following:

- Allow the tongue/lip/cheeks to move in a greater range of motion
- Improve breastfeeding/bottle-feeding comfort and efficiency
- Improve reflux/digestive symptoms, body tension, oral posture and/or sleep patterns
- Reduce the severity of speech and eating difficulties

Risks and complications of this treatment include but are not limited to:

- Lack of improvement
- Post-surgical bleeding, pain, swelling, feeding aversion
- Re-attachment of the frenulum or development of scar tissue that may cause a return of the original symptoms
- Possible need for a second procedure (if the initial results are not satisfactory)
- Injury to adjacent structures: salivary glands, ducts, nerve, muscle and skin
- Rare possibility:

  infection, numbness, allergic reaction, aspiration

- Very rare possibility:

  Vitamin K deficiency bleeding or other undiagnosed bleeding disorder

  Complications due to underlying medical conditions

Supplemental records and their use:

I consent to photography and filming of my child's oral structures and/or release procedure for educational use in lectures, social media, or publications provided my child's identity is not revealed.

Necessary follow-up and self-care:

I understand that it is my responsibility to adhere to wound care instructions and follow up appropriately with recommended health care professionals (IBCLC/bodyworker/SLP/OT etc.). I will need to come for post-op appointments with Dr. Dabir so he can monitor and evaluate my child's healing. Failure to comply could lead to an unsatisfactory or sub-optimal outcome.

I have read and fully understand the terms and words within this document. The benefits and possible risks were discussed as well as alternative care options, including no treatment or bodywork/oral motor therapy.

I agree to the procedure(s) checked below:

☐ Lingual Frenectomy ☐ Labial Frenectomy ☐ Right Buccal Frenectomy ☐ Left Buccal Frenectomy

Please circle and initial below:

I accept treatment _____

I decline treatment _____

Patient Name: _____

Signature of parent/legal guardian: _____

Date: _____

Doctor Signature: _____

Date: _____

Grow Well Kids

3257 Camino De Los Coches Suite 308 Carlsbad, CA 92009

760-203-3468