Infant Frenectomy Parent Consent

I acknowledge that the doctor has explained my child's condition and the proposed frenectomy procedure. I understand the risks of the procedure, including the risks that are specific to my child and the likely outcomes. I was able to ask questions and raise concerns with the doctor about my child's condition, the procedure and its risks, and treatment options. My questions and concerns have been discussed and answered to my satisfaction. I understand that photographs or video footage may be taken during my child's procedure and these may be used for educational or marketing purposes. (Your child will not be identified in any photo or video). I understand that no guarantee has been made that the procedure will improve the condition and that the procedure may make my child's condition worse. On the basis of the above statements, I REQUEST THAT MY CHILD HAS THE PROCEDURE.

Name of Patient AND Parent: _____

_____

Signature of Parent/Substitute decision maker:

_____ Date:_____

For the Office:_____

DE PERE SMILES s.c.

Infant Tongue / Lip Tie Questionnaire

Parent and infant's name: _____ Birthdate: _____

Male_____ Female_____ Birth weight _____ Present weight _____

Birth: _____Home birth _____Hospital birth _____Vaginal birth _____C-section birth

Are you presently breastfeeding? _____yes _____no If no, how long since you stopped? _____

Parent's Name: _____

Medical History: Has your child experienced any of the following problems or treatment?

1. *Infants are usually given vitamin K at birth to prevent bleeding in the first 8 weeks of life. Did you sign any waiver to refuse the administration of vitamin K?* ____yes ____no
2. Does your infant have any *bleeding disorders*? ____yes ____no
3. Was your infant born *premature*? ____yes ____no
4. Does your infant have *heart disease*? ____yes ____no
5. Has your infant had *any surgery*? ____yes ____no
6. Does your infant have any *allergies*? ____yes ____no
7. Has your infant had a prior surgery to correct the tongue or lip tie? ____yes ____no
8. Is your infant taking any *medications*? ____yes ____no List _____
9. Has your infant taken any pain medication today? ____yes ____no
10. Is it ok to give your infant pain medication today? ____yes ____no

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Has **your infant** had any of the following?

YES / NO

- ☐ ☐ Poor latch
- ☐ ☐ Falls asleep while attempting to nurse
- ☐ ☐ Slides off nipple when trying to latch
- ☐ ☐ Colic symptoms
- ☐ ☐ Reflux symptoms (due to excessive clicking or air intake)
- ☐ ☐ Poor weight gain
- ☐ ☐ Gumming/chewing nipple when nursing
- ☐ ☐ Unable/unwilling to take pacifier
- ☐ ☐ Short sleep episodes requiring feeding every 1-2 hours

Pediatrician_____

Phone number_____

Address_____

City_____State____Zip_____

Do **you** have any of the following?

YES / NO

- ☐ ☐ Creased, flattened or blanched nipples after nursing
- ☐ ☐ Cracked, bruised, or blistered nipples
- ☐ ☐ Bleeding nipples
- ☐ ☐ Severe pain when your infant attempts to latch
- ☐ ☐ Poor or incomplete breast drainage
- ☐ ☐ Infected nipples or breasts
- ☐ ☐ Plugged ducts or mastitis
- ☐ ☐ Nipple thrush

***Patient MUST be evaluated by a lactation consultant prior to being seen by Dr. Peterson.

Lactation consultant_____

Phone number_____

Address_____

City_____State____Zip_____

**I certify that the information provided on this form is correct to the best of my knowledge.

_____

Parent or Guardian's Signature

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