Offer **Parental Information Leaflet** on Tongue Tie

**BTAT Scoring**

**(Bristol Tongue Assessment Tool) –** Record Score & plan in Red Book

**Score ≥6** – continue additional breastfeeding support

Feeding difficulties persist after at least **24 -48 hours** additional breastfeeding support

**BREASTFED INFANT**

Feeding Difficulties **AND** Concern regarding Tongue Tie

**HOSPITAL**

Review by Paediatric Registrar/ Consultant or Infant Feeding Specialist Midwife using BTAT Scoring

**COMMUNITY**

Review by GP, Midwife or Health Visitor using BTAT Scoring

**HOSPITAL**

If URGENT referral due to clinical concerns, Paediatric Registrar or Consultant to discuss directly with ENT Registrar or Consultant

**Score ≤5 - Refer to ENT**

**for assessment and consideration of division**

Complete Details overleaf & email (Specify ‘Tongue Tie Referral’) [**gwh.bookingcentre@nhs.net**](mailto:gwh.bookingcentre@nhs.net)

OR **Fax 01793 604406**

**ENT Admin**

take copy for file, pass original to Health Records for registration, record appt dates made for each referral

Next available ENT appointment to be allocated **If not available within 1 week,**  senior ENT clinician to triage and organise urgent extra appointment

**ENT**

Complete audit sticker in notes. Communicate outcome of assessment to referrer.

**Refer to Specialist Infant Feeding Clinic** [gwh.infantfeedingmidwives@nhs.net](mailto:gwh.infantfeedingmidwives@nhs.net) or 01792 604726 **for**

* Ongoing feeding problems after TT divided (but **please also re-refer to ENT via above mechanism for re-assessment in tongue tie clinic**)
* BTAT ≤5 but division not required (or parents decline) after ENT assessment
* BTAT ≥6 but ongoing feeding problems

|  |  |  |  |
| --- | --- | --- | --- |
| Baby’s Name: |  | Mother’s name: |  |
| Baby’s DoB: |  | Baby’s NHS No or Hospital No: |  |
| Address:  Postcode: |  | Home Tel No: |  |
| Mobile No: |  |
| GP Surgery label: | |

**Bristol Tongue Assessment Tool**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **0** | **1** | **2** | **Score** |
| **Tongue tip appearance** | Heart shaped | Slight cleft /notched | Rounded |  |
| **Attachment of frenulum to lower gum ridge** | Attachment at top of gum ridge | Attached to inner aspect of gum | Attached to floor of mouth |  |
| **Lift of tongue with mouth wide (crying)** | Minimal tongue lift | Edges only to mid-mouth | Full tongue lift to mid-mouth |  |
| **Extension of tongue** | Tip stays  behind gum | Tip over gum | Tip can extend over lower lip |  |

**TOTAL BTAT SCORE =** SCORE ≤ 5 = REFER TO ENT FOR ASSESSMENT

**THIS BABY RECEIVE IM VITAMIN K AT BIRTH?** Yes No

Please give add feeding history and further assessment information below

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of**  **Referrer:** |  | **Designation**  **/role:** |  | |
| **Contact Tel No:**  **Contact email:** |  | **Date referral sent:** |  | |
|  |
|  |  |  | *Initials* | |
| **For office use:** | Date Referral Received: |  | |  |
| Date Sent to Registration: |  | |  |
| Date Sent to Booking Centre: |  | |  |
| Date of Clinic Appointment: |  | |  |