CHARLESTON PEDIATRIC DENTISTRY
INFANTS | CHILDREN | YOUNG ADULTS

Referral for Tethered Oral Tissue Evaluation

REFERRING PROVIDER INFORMATION	
Name:	
Credentials (IBCLC, SLP, OT, PT, Other):	Practice Name:
Phone:	E-mail:

PATIENT INFORMATION	
Child's Name:	
Date of Birth:	Age:
Parent/Guardian Name:	Contact Number:

Please Note: Infant/Child must be in active therapy with a SLP, OT, PT or IBCLC, having received 2-4 sessions prior to referral. The patient must see the referring provider within 30 days of a procedure. Families that are not compliant with appointments should not be referred.

PRIMARY CONCERN(S) - *Check all that Apply*

- ☐ Breastfeeding difficulties (latch issues, nipple pain, poor milk transfer)
- ☐ Bottle-feeding challenges
- ☐ Difficulty with solid foods (chewing/swallowing)
- ☐ Speech articulation concerns
- ☐ Oral motor tension/limited tongue mobility
- ☐ Reflux/digestive symptoms
- ☐ Sleep/breathing disturbances
- ☐ Other:

CLINICAL FINDINGS - *Check all that Apply*

- ☐ Lingual restriction (tongue-tie)
- ☐ Maxillary labial restriction (lip-tie)
- ☐ Buccal restrictions (cheek-tie)
- ☐ High muscle tension in oral/facial structures
- ☐ Functional concerns noted during assessment

MEDICAL HISTORY

Is there a family history of bleeding disorders? ☐ Yes ☐ No	History of MTHFR gene mutation? ☐ Yes ☐ No ☐ Unknown
Any significant medical conditions affecting feeding or development? ☐ Yes ☐ No If yes, please specify:	
Any known allergies? ☐ Yes ☐ No If yes, please specify:	
Any other relevant medical history?	

THERAPY & FEEDING PROGRESS

Has the patient started therapy? ☐ Yes ☐ No	Type of therapy (IBCLC, SLP, OT, PT, Other):
Number of therapy sessions completed:	Has feeding improved with therapy? ☐ Yes ☐ No ☐ Partial Improvement
Will the patient continue follow-up with the referring provider? ☐ Yes ☐ No	

ADDITIONAL NOTES/RECOMMENDATIONS

REQUESTED EVALUATION & CONSIDERATION FOR TREATMENT

I am referring this patient for a comprehensive evaluation of the maxillary labial and lingual frenum for possible frenectomy. I request an assessment to determine whether a release procedure would be beneficial based on clinical findings and functional concerns.

Referring Provider Signature

Date: