Sprout
PEDIATRIC DENTISTRY

frenectomy patient referral form

Amanda Hankins, DDS
Waterlase|Biolase Frenectomy

introducing

First Name _____ Last Name _____ DOB _____
Parent Name _____ Phone Number _____

referring practitioner details

Practice Name _____ Referring Practitioner _____
Phone Number _____ Remarks _____

please indicate symptoms reported

- ❑ shallow or weak latch
- ❑ clicking sounds
- ❑ frequent/excessive reflux
- ❑ excessive gas or colic
- ❑ other
- ❑ fatigues quickly during feeding
- ❑ excessive/frequent feedings
- ❑ lip blister or callus
- ❑ little or no weight gain
- ❑ body work needed (please indicate side)

older children

- ❑ delayed/affected speech
- ❑ difficulty swallowing
- ❑ gags easily on food/liquid
- ❑ gap between front teeth
- ❑ other

recommended revision

❑ Lip and Tongue ❑ Lip Only ❑ Tongue Only ❑ No treatment: consultation only