	Affix Patient Label	
	Patient Name:	Date of Birth:

Informed Consent For Frenotomy

This information is given to you so that you can make an informed decision about your baby having **frenotomy**.

Reason and Purpose of the Procedure:

Ankyloglossia, or tongue-tie, happens when a frenulum (ridge of tissue) under the tongue does not allow full movement of the tongue. This can cause problems with feeding.

A small cut made in the frenulum to help the tongue move is called **frenotomy**.

We will put some ointment that is a numbing medicine on your baby's frenulum to help him/her be comfortable during the procedure. A small amount of sugar solution may also be given by mouth to help comfort your baby.

Benefits of this surgery:

Your baby may have the following benefits. Your doctor cannot promise your baby will receive any of these benefits. Only you can decide if the benefits are worth the risk.

- Increase the movement of the tongue.
- Improve breast feeding latch and reduce mother's pain with breast feeding.
- Increase mother's milk supply due to improved feeding.
- Decrease spitting up.

Future Benefits May Include:


- Improved speech.
- Improved oral health.

Risks of this procedure:

No procedure is completely risk free. Some risks are well known. There may be risks not included in the list that your doctor cannot expect.

Specific risks of frenotomy:

- Bleeding. A small amount of bleeding is common.
- Pain.
- Injury to the tongue, tongue muscles or the salivary glands. This is rare.
- May need to repeat this procedure if the frenulum grows back together or more needs to be cut.
- Infection. Your child may have to be treated with antibiotics. This is rare.

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The risks of bleeding could increase if:

- There is a family history of bleeding.
- The infant has a bleeding disorder.
- The mother was taking blood thinners during pregnancy.

Risks Specific to Your Baby:

Alternative Treatments to Frenotomy:

Other choices:

- Working with a breastfeeding specialist or speech pathologist may help your child.
- Frenotomy can be done when your baby is older.

If You Choose Not to Have this Treatment Now:

- Your baby may not be able to feed well enough to gain weight or stay hydrated.
- Breast feeding may become too uncomfortable to continue.
- The mother’s milk supply may decrease or not come in if your baby is unable to feed well.
- Your child may need to see an oral specialist if this procedure is done when he or she is older.

General Information:

- During this procedure, the doctor may need to perform more or different procedures than I agreed to.
- Students, technical sales people and other staff may be present during the procedure. My doctor will supervise them.



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Patient Name: _____

Date of Birth: _____

By signing this form I agree:

- I have read this form or had it explained to me in words I can understand.
- I understand its contents.
- I have had time to speak with my child's doctor. My questions have been answered.
- I want to have this procedure: **Frenotomy**
- I understand that my child's doctor may ask another doctor with the same skills to do the procedure.
- I understand that other doctors, including medical residents, or other staff may help with surgery. The tasks will be based on their skill level. My doctor will supervise them.

Parent Signature _____ Date: _____ Time: _____

Relationship: ☐ Parent

☐ Guardian

Interpreter's Statement: I have translated this consent form and the doctor's explanation to the patient, a parent, closest relative or legal guardian.

Interpreter: _____ Date _____ Time _____

Interpreter (if applicable)

For Provider Use ONLY:

I have explained the nature, purpose, risks, benefits, possible consequences of non-treatment, alternative options, and possibility of complications and side effects of the intended intervention, I have answered questions, and parent has agreed to procedure.

Provider signature: _____ Date: _____ Time: _____

Teach Back

Parent shows understanding by stating in his or her own words:

____ Reason(s) for the treatment/procedure: _____

____ Area(s) of the body that will be affected: _____

____ Benefit(s) of the procedure: _____

____ Risk(s) of the procedure: _____

____ Alternative(s) to the procedure: _____

Or

____ Parent elects not to proceed: _____ (parent signature)

Validated/Witness: _____ Date: _____ Time: _____