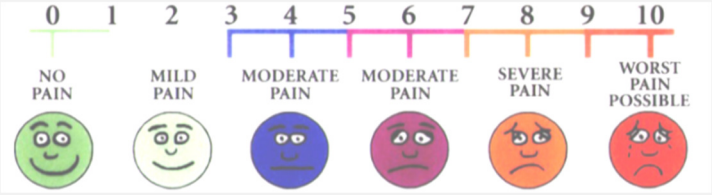
Patient Name: _____Sex:_____
Date of Birth: _____
Today's Date: _____
Mother's name: _____
Mother's age: _____

Feeding Evaluation 0 – 12m (Consult)



What is your pain level when nursing from 1-10?
On average, how many minutes per feeding is child on the breast?
In the last 24 hours, how many times did you breastfeed the baby?
In the last 24 hours, how many times did you bottle feed the baby?
In the last 24 hours, how many times did you syringe feed the baby?
If you bottle feed pumped breast milk, how many ounces of breastmilk did you feed?
If you bottle feed formula, how many ounces did you feed?

How Often:	Never	<25%	50%	>75%	100%
Is the time between feedings less than 2 hours?					
Does the infant sleep less than 2 hours between feedings?					
Does the infant get tired or get frustrated during breastfeeding?					
Does the infant have a shallow latch?					
Does the infant click during breastfeeding?					
Does the infant latch on and off the nipple during breastfeeding?					
Does the infant tuck the lip under/in during feeding?					
Does the infant choke/ gag during breastfeeding?					
Does the infant hiccup immediately after breastfeeding?					
Does the infant cough during breastfeeding?					
Do you feel the baby empties your breasts?					
Do you feel the baby is fussy right after feeding?					

How Often:	Never	<25%	50%	>75%	100%
Do you feel the baby has excessive gas?					
Do you have nipple pain during breastfeeding?					
Does the infant chew/ gum/ clench/ clamp down/ bite the nipple during breastfeeding?					
Do you notice blanching (fading/ whitening/ discoloration) of the nipples with breastfeeding?					
Does the infant spit up after breastfeeding?					
Do you see milk coming out of the nose after/ during feeding?					
Does the child arch his/ her back during/ after feeding?					
Do you use a nipple shield?					
Does your child leak from the corners of mouth during/ after feeding?					

	Yes	No
Are your nipples cracked?		
Has the child been diagnosed with GERD (Reflux)?		
Has the child been prescribed any medication for GERD (Reflux)?		
Is this your first baby?		
Have you breastfed before this baby?		
Is there a family history of tongue ties?		
Has anyone else had the procedure in the family?		
Is there a family history of sleep apnea?		
Is there a family history of GERD?		
Is there a family history of speech issues?		
Have you experienced clogged ducts in the breast?		
Have you been diagnosed with thyroid disease?		
Have you been diagnosed with postpartum depression?		
Have you been diagnosed with Diabetes?		
Have you been diagnosed with Polycystic Ovarian Disease?		
Have you had any form of breast surgery?		
Are you on any medications?		
If yes, which?		
Have you had mastitis?		
If yes, how many times and which side?		
Are you working with IBCLC?		

CONSENT TO ACT AS A PARTICIPANT IN A RESEARCH REGISTRY

TITLE: Agave Pediatrics Tongue-tie Research Registry

PRINCIPAL INVESTIGATOR: Dr. Rajeev Agarwal

CO-INVESTIGATORS: Agave Pediatric Providers and Research Staff

SOURCE OF SUPPORT: Currently self-funded

Advancements in patient care have resulted from research involving the collection and analysis of health care records of patients with a certain disease or condition. It is anticipated that this will assist researchers with the review and study of medical records to answer questions about tongue-tie and its treatment.

If you agree to participate in the Agave Pediatrics Tongue-tie Research Registry the mother's report about breastfeeding and infants past, current and future health care record will be placed into the Research Registry. .

There will be no costs to you or your insurance provider to participate in this Research Registry.

No, you will not receive any payment for participating in this Research Registry.

Any information from your medical records that is placed into this Research Registry will be kept as confidential (private) as possible. In addition, you will not be identified by name in any publication of the results of research studies involving the use of your medical record information unless you sign a separate consent form (release) giving your permission.

Access to your identifiable medical record information contained within this Research Registry will be limited to investigators associated with the Agave Pediatrics and their research staffs. A current, complete listing of these individuals will be provided to you upon your written request.

CERTIFICATION OF INFORMED CONSENT

I certify that I have explained the nature and purpose of the Agave Pediatrics Tongue-tie Research Registry to the above-named individual, and I have discussed the possible risks and potential benefits of participation in this Research Registry. Any questions the individual has about this Research Registry have been answered, and the providers and research staff associated with Agave Pediatrics will be available to address future questions as they arise.

_____

Patient Name

_____ _____

Parent Signature Date