Enclave DENTAL

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ONE WEEK POST OP VISIT AFTER FRENECTOMY

Name: **DOB**

Date:

Infant:

- Baby is more alert: Y/N
- Feeding is more efficient and there is better transfer of milk: Y/N
- Weight gain: Y/N If yes, by how much: _____
- Longer sleep times: Y/N
- Is baby happier: Y/N
- Less spitting up: Y/N
- Less Burping: Y/N
- Less leaking of milk from corners of mouth: Y/N
- Nursing blister gone: Y/N
- Latching improved: Y/N
- Lips curl up and out :Y/N
- Tongue movement improved: Y/N
- Tongue movement: Side to side: Y/N
    - Sticks out more: Y/N

Mother:

- Better breastfeeding relationship: Y/N
- Less discomfort: Y/N
- Using shields: Y/N
- More baby and mom eye contact while feeding: Y/N

Any additional comments: _____

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