ONE SKY
FAMILY MEDICINE

Tongue Tie/Feeding Evaluation/Frenotomy Referral

Fax to 206-363-5533

BABY

Name: _____

DOB: _____ Sex:_____

BREASTFEEDING PARENT

Name: _____

DOB:_____Sex: _____

Vitamin K admin'd? ☐ IM ☐ oral ☐ refused

☐ Baby's pediatric provider: _____ , OR
☐ Please continue baby's primary care

INSURANCE (or attach demographics sheet):

Plan name: _____

Member ID:_____ Group ID: _____

Policy holder's name: _____

Policy holder's DOB: _____

It is the family's responsibility to confirm insurance coverage for this procedure BEFORE the visit.

☐ Please call family to schedule OR ☐ Family will call 206-363-5555 to schedule

Phone:_____

☐ Urgent OR ☐ Routine

Notes:

Referred By: _____

☐ Delivering provider ☐ Lactation consultant ☐ PCP ☐ Other:
☐ Please send visit notes to this fax #:

Please refer families to http://www.oneskyfamilymedicine.com/services/frenotomy-tongue-tie-release/ for instructions on how to prepare for this visit and verify insurance coverage.

Thank you for the opportunity to help care for your patients! Elias Kass, ND, LM, CPM

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