

**CONTRIBUTED BY**

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**INFANT POST-OP VISIT**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Infant:**

Child more alert: Y/ N

Feeding times more efficient (better transfer): Y/ N

Weight Gain: Y / N If changed, by how much? \_\_\_\_\_\_\_\_\_\_

Longer Sleeping Times: Y / N

If changed, by how much?\_\_\_\_\_\_\_\_\_\_\_\_\_\_

General feeling of a happier baby: Y / N

Less burping: Y / N / Never was a problem

Less spiting up: Y / N / Never was a problem

Milk leaks from corners of the mouth: Y / N / Never Did

Less Flatulence: Y/ N / Never was a problem

Nursing blister gone: Y / N / Never Had One

Nasal breathing during nursing improved: Y / N / Never a Problem

Tongue movement improved: Y / N / Not Applicable

Baby does rhythmic drinking instead of gulps: Y / N

Tongue: Moves side to side: Y/N Tongue: sticks out more Y/N

**Mother:**

Less discomfort: Y / N / Never was an issue If there were nipple shape changes pervious to treatment, are they better now? Y/N If yes, how:\_\_\_\_\_\_\_\_\_\_\_\_

Using shields: Y / N / Never Did

Lip curls up and out during nursing: Y / N

Breast milk production better: Y / N / Never was a problem

Latching efficiency improved: Y / N / No change

More baby/ mother eye contact during nursing: Y / N / Never was a problem

*Are you happy with the results of your baby’s treatment? Please share any comments you may have.*

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