The Impact of Lingual Frenotomy on Bottle Feeding Mechanics: a Randomized, Controlled Trial

PI: Bobby Ghaheri, MD
The Oregon Clinic, 1111 NE 99th Avenue, Portland, OR. 97220

Breastfeeding Confidence (BSES-SF)

INSTRUCTIONS: For each of the following statements, please choose the answer that best describes how confident you are with breastfeeding your new baby. Please mark your answer by circling the number that is closest to how you feel. There is no right or wrong answer. Please mark one answer on every question.

1 = not at all confident
2 = not very confident
3 = sometimes confident
4 = confident
5 = very confident

Date completed:_____

		Not at all Confident				Very Confident
1.	I can always determine that my baby is getting enough milk.	1	2	3	4	5
2.	I can always successfully cope with breastfeeding like I have with other challenging tasks.	1	2	3	4	5
3.	I can always breastfeed my baby without using formula as a supplement.	1	2	3	4	5
4.	I can always ensure that my baby is properly latched on for the whole feeding.	1	2	3	4	5
5.	I can always manage the breastfeeding situation to my satisfaction.	1	2	3	4	5
6.	I can always manage to breastfeed even if my baby is crying.	1	2	3	4	5
7.	I can always keep wanting to breastfeed.	1	2	3	4	5
8.	I can always comfortably breastfeed with my family members present.	1	2	3	4	5
9.	I can always be satisfied with my breastfeeding experience.	1	2	3	4	5
10.	I can always deal with the fact that breastfeeding can be time consuming.	1	2	3	4	5
11.	I can always finish feeding my baby on one breast before switching to the other breast.	1	2	3	4	5
12.	I can always continue to breastfeed my baby for every feeding.	1	2	3	4	5
13.	I can always manage to keep up with my baby's breastfeeding demands.	1	2	3	4	5
14.	I can always tell when my baby is finished breastfeeding.	1	2	3	4	5

Internal use: Study ID # _____ Baby initials _____ Baby DOB _____MRN_____

DATA COLLECTION TIME:

Observation Group (circle): **Initial Encounter (Day 0)** **Treatment (Day 10)** **10 Day Postop (Day 20)**

Treatment Group (circle): **Initial Encounter (Day 0)** **10 Day Postop (Day 10)**

GSQ-I Survey Instrument

RELATIONSHIP TO SUBJECT:

☐ **Mother** ☐ **Step Mother** ☐ **Grandmother** ☐ **Guardian**

☐ **Father** ☐ **Step Father** ☐ **Grandfather** ☐ **Other, specify**_____

SYMPTOMS	**QUESTION A** How many times did each symptom occur in the past 7 days? (such as 0, 1, 2, 3, etc.)	**QUESTION B** On a scale of 1 to 7 how severe was the symptom usually? **1 = Not at all severe 7=Most severe** (leave question B blank if your answer to question A is "0")
1. VOMITING / REGURGITATION Throwing up / swallowing food or liquids that have come back up into the child's mouth.	|____|____| **Times in the past 7 days** (Do not leave blank)	**Not at all Severe** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** **Most Severe**
2. IRRITABILITY / FUSSINESS Episodes of crying during feeding or inconsolable.	|____|____| **Times in the past 7 days** (Do not leave blank)	**Not at all Severe** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** **Most Severe**
3. REFUSAL TO FEED	|____|____| **Times in the past 7 days** (Do not leave blank)	**Not at all Severe** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** **Most Severe**
4. CHOKING / GAGGING	|____|____| **Times in the past 7 days** (Do not leave blank)	**Not at all Severe** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** **Most Severe**
5. ARCHING BACK	|____|____| **Times in the past 7 days** (Do not leave blank)	**Not at all Severe** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** **Most Severe**

Internal use: Study ID # _____ Baby initials _____ Baby DOB _____ MRN_____

DATA COLLECTION TIME:

Observation Group (circle): Initial Encounter (Day 0) Treatment (Day 10) 10 Day Postop (Day 20)

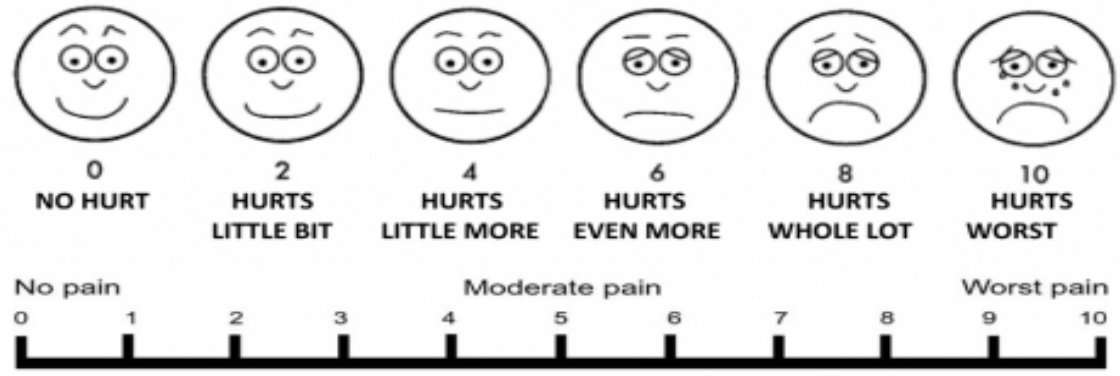
Treatment Group (circle): Initial Encounter (Day 0) 10 Day Postop (Day 10)

6. EPISODES OF HICCUPS	|____|____| **Times in the past 7 days** (Do not leave blank)	**Not at all Severe** ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 **Most Severe**
7. OTHER: specify symptom below	|____|____| **Times in the past 7 days** (Do not leave blank)	**Not at all Severe** ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 **Most Severe**
8. OTHER: specify symptom below	|____|____| **Times in the past 7 days** (Do not leave blank)	**Not at all Severe** ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 **Most Severe**

Current Pain with Breastfeeding:

(please circle one number)

Using the scale below, please rate your current **pain** with breastfeeding on a scale of **1 – 10:**



Thank you. We appreciate your time with this study.

Internal use: Study ID # _____ Baby initials _____ Baby DOB _____MRN_____

DATA COLLECTION TIME:

Observation Group (circle): Initial Encounter (Day 0) Treatment (Day 10) 10 Day Postop (Day 20)

Treatment Group (circle): Initial Encounter (Day 0) 10 Day Postop (Day 10)

For Research Personnel Use Only:

☐ ☐ **(check appropriate box)**

STILL BREAST FEEDING: YES NO

BOTTLE FEEDING DATA:

BABY/INFANT NAME: _____

NOTES:

Day 0 (Initial Encounter – Treatment Group and Control Group) **:**
Day 0 (Treatment Group – Immediate Post-procedure) **:**
Day 10 (Treatment Group – 10 Day Post-procedure)**:**
Day 10 (Observation/Control Group, Pre-procedure) **:**
Day 10 (Observation/Control Group, Immediate Post-procedure):
Day 20 (Observation/Control Group, 10 Day Post-Procedure):

Internal use: Study ID # _____ Baby initials _____ Baby DOB _____ MRN_____

DATA COLLECTION TIME:

Observation Group (circle): Initial Encounter (Day 0) Treatment (Day 10) 10 Day Postop (Day 20)

Treatment Group (circle): Initial Encounter (Day 0) 10 Day Postop (Day 10)