Dublin Cleft Centre Team - Referral for Cleft Management Services

☐ Children's Health Ireland at **Temple Street** Cleft Surgeon: Mr Christoph Theopold

☐ Children's Health Ireland at **Crumlin** Cleft Surgeons: Mr David Orr ☐, Ms Catherine de Blacam ☐

Family Details

Infant's name: _____ M ☐ F ☐ Mother's DOB: ___ /___/___

Parent Name: _____ phone: _____

Parent Name: _____ phone: _____

Address: _____

_____

Nationality: _____ First Language: _____ Sibling's ages: _____

Interpreter required? Yes ☐ No ☐ Language /Dialect: _____

GP details: _____

Medical Details:

Date of Birth: _____ Time of Birth: _____ Gestation: _____ Cleft: lip only☐ palate only☐ both☐

Birth Weight: _____ Length: _____ OFC: _____ Apgar Score: _____

Delivery Mode: _____ Parity: _____

Maternal Health: _____

Medications during pregnancy: _____

Cleft Family History ? Yes ☐ No ☐ Details: _____

Airway Assessment: (this should be completed prior to 1st oral feed)

Micrognathia: Yes ☐ No ☐

If Yes check tongue position: Anterior☐ Mid oral☐ Retro positioned☐ SaO2 readings _____

Tick as appropriate

Normal Airway/Breathing: Yes☐ No☐ (if No consider cleft team liaison prior to oral feeding)

Increased work of breathing ☐ Nasal flaring ☐ Audible sounds ☐ Tracheal Tug ☐

Use of Accessory Muscles ☐ Dusky episodes ☐ O2 Desaturation on handling ☐

PCO2 Levels: _____ Nursing position: Supine ☐ Side-lying ☐ Prone ☐

Feeding: (airway assessment should be completed prior to 1st feed)

Mother's Feeding Preference: Breast ☐ Bottle ☐ Combination ☐

Previous breastfeeding experience Yes ☐ No ☐ Details: _____

1st oral feed offered by breast ☐ standard bottle ☐ Other _____

Feeding at time of cleft referral: Nil PO☐ Breast☐ Bottle☐ NG tube☐ Combination PO/NG ☐

Describe present feeding: _____

Bottle Type: Standard bottle☐ Haberman☐ Mam soft☐ Exclusive Breast☐ Other ☐_____

Investigations:

Bloods reserved Yes ☐ No ☐ _____

Neonatal Audiology Screening Yes ☐ No ☐ _____

Other Investigations/Referrals: _____

_____

Cleft Diagnosis:

Antenatal Diagnosis: Yes ☐ No ☐

Antenatal anomaly scan available in unit Yes ☐ No ☐ Antenatal scan offered Yes ☐ No ☐

Antenatal scan attended Yes ☐ No ☐ Antenatal Cleft Team referral Yes ☐ No ☐

Time of Diagnosis post Birth (in hours of age): _____ Birth -24hrs ☐ 24-48hrs ☐

48-72hrs ☐ 72hrs-1 week ☐ 1week-1month ☐ 1month-6months ☐ >6months ☐ _____

Referring Professional Information:

Name of Referrer: _____ Title of person 1st recognizing cleft _____

Team Consultant: _____ Neonatologist ☐ Paediatrician ☐

Referring Hospital/Centre/Address: _____

_____

Contact No. _____ Fax: _____ Email: _____

Date/Time referred to Cleft Team: Date _____ Time _____

(Please contact a cleft team member as soon as possible following diagnosis – phone preferable for initial communication)

Initial Cleft referral mode: Phone☐ Email☐ Fax☐ Post☐

Referral communicated to: Co-ordinator☐ Nurse Specialist☐ Secretary☐ Plastic Surgeon☐

Plastics Registrar☐ Speech & Language☐ Other: _____

Plan for local follow-up arrangements:_____

(Local Paediatrician follow-up recommended for growth & developmental monitoring when palatal involvement)

(Official Cleft Team Use) Cleft team antenatal reference: _____ N/A ☐

Date of Contact: (1) Hospital _____ (2)Parent _____

Cleft Team Consultation Clinic (time/date): _____

Information Supplied: CLAPAI leaflets Yes ☐ No ☐ Cleft website information Yes ☐ No ☐

Other _____

Cleft Team Referrals: Speech & Language Therapist Yes ☐ No ☐ Other _____

Comments: _____

NB please refer to one Cleft Team only

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Children's Health Ireland at Temple Street

Children's Health Ireland at Crumlin

 Further information: www.cleftcareireland.ie