

Dublin Cleft Centre Team
Antenatal Referral form for Cleft Management Services



- ☐ Children's Health Ireland at **Temple Street** Cleft Surgeon: Mr Christoph Theopold
☐ Children's Health Ireland at **Crumlin** Cleft Surgeon: Ms Catherine de Blacam

Patient contact phone number(s):

Home: _____
Mobile: _____
Partner's name/mobile: _____
Language spoken: _____
Interpreter required: Yes ☐ No ☐
Siblings: _____

Patient details/ID Sticker

Name: _____
Address: _____
DOB: _____
M.R.N. _____
Mother's email: _____

Referring Details:

Expected Date of Delivery: _____
Referrer: OBS ☐ M/Wife ☐ Sonographer ☐
Name: _____
Referring Consultant: _____
Date of Cleft diagnosis on Ultrasound Scan:
____ / ____ / ____
Findings: _____

Any other anomalies/relevant maternal
history: _____

- 1) Referring Hospital: _____
- 2) Hospital of origin: _____
- 3) Hospital of delivery: _____
- 4) Primary Obstetrician: _____

Date of Referral to Cleft Team

(if possible, please attach copy of scan)

Family History of Cleft: Yes ☐ No ☐

Details (if yes): _____

(Official Cleft Team Use)

Preference for feeding: Breast ☐ Bottle ☐ Combination ☐ Undecided ☐
Date of Contact: (1) Hospital ____ / ____ / ____ (2) Expectant Mum ____ / ____ / ____
Information Supplied: CLAPAI details ☐ Cleft website ☐ Team contacts ☐
Other _____
If information posted: date posted ____ / ____ / ____
Antenatal Cleft Consultation: Date _____ Time _____
Follow up action required: _____

NB please refer to one Cleft Team only

Further information: www.cleftcareireland.ie

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Nurse Specialist
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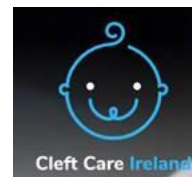
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Additional Information:

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