**Postnatal Referral – please complete ALL the information**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Referring Hospital:** | | | | | | | | | | | | Click or tap here to enter text. | | | | | | | | | | | | | | | | | | | | | | |
| **Full Name & Designation of Referrer:** | | | | | | | | | | | | Click or tap here to enter text. | | | | | | | | | | | | | | | | | | | | | | |
| **Date and Time of referral:** | | | | | | | | | | | | Click or tap here to enter text. | | | | | | | | | | | | | | | | | | | | | | |
| **Contact details (Please include direct line number):** | | | | | | | | | | | | Click or tap here to enter text. | | | | | | | | | | | | | | | | | | | | | | |
| **Baby Information** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Baby’s name:** | | | Click or tap here to enter text. | | | | | | | | | | | | | **DOB:** | | | | Click or tap here to enter text. | | | | | | | | | **Time of birth:** | | | | Click or tap here to enter text. | |
| **SEX:** | MALE | | | | | FEMALE | | | | | | | | | **Gestation:** | | | | | Click or tap here to enter text. | | | | | | | | **EDD:** | | | Click or tap here to enter text. | | | |
| **NHS. No:** | | | | Click or tap here to enter text. | | | | | | | | **Hospital Number (local):** | | | | | | | | | | | Click or tap here to enter text. | | | | | | | | | | | |
| **Type of Birth:** | | | | Click or tap here to enter text. | | | | | | | | **Birth Weight:** | | | | | | | Click or tap here to enter text. | | | | | | | **HC:** | | | | Click or tap here to enter text. | | | | |
| **Cleft Diagnosis:** See photos for reference | | | | | | | | | | | | Click or tap here to enter text. | | | | | | | | | | | | | | | | | | | | | | |
| **Date of Diagnosis:** | | | | Click or tap here to enter text. | | | | | | | | | | | | | | | | | | **Time of Diagnosis:** | | | | | | | | Click or tap here to enter text. | | | | |
| **APGAR SCORES [choose from the drop down.]** | | | | ?? @ 1 Mins | | | | | | | | | | | | ?? @ 5 Mins | | | | | | | | | | | ?? @ 10 Mins | | | | | | | |
| **Other medical conditions: Please include any suspected anomalies, breathing concerns etc.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Click or tap here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Micrognathia:** | | | | | | | | YES | | | | | NO | | | | | **Glosoptossis**: | | | | | | | | | | | | YES | | | | NO |
| **Baby’s current location:** | | | | Labour Unit | | | | | | | Postnatal | | | | | | NICU | | | | | | | Special Care | | | | | | | | Home | | |
| **Other Please specify:** | | | | | | Click or tap here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **NIPE completed:** | | | | | YES | | | | | NO | | | | | | **Ethnicity:** | | | | | | | | | Click or tap here to enter text. | | | | | | | | | |
| **Interpreter required:** | | | | | YES | | | | | NO | | | | | | **Language spoken:** | | | | | | | | | Click or tap here to enter text. | | | | | | | | | |
| **Known to Social care:** | | | | | YES | | | | | NO | | | | | | **Social Workers Name:** | | | | | | | | | Click or tap here to enter text. | | | | | | | | | |
| **Social Workers Contact Telephone no.** | | | | | | | | | | | | Click or tap here to enter text. | | | | | | | | | | | | | | | | | | | | | | |
| **Contact information** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Mothers Name:** | | | | Click or tap here to enter text. | | | | | | | | | | | | | | | | | | **Mother DOB:** | | | | | | | | Click or tap here to enter text. | | | | |
| **Home Address:** | | | | Click or tap here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Contact telephone no.** | | | | **Home** | | | | | Click or tap here to enter text. | | | | | | | | | | | | **Mobile** | | | | | | Click or tap here to enter text. | | | | | | | |
| **GP: Name:** | | Click or tap here to enter text. | | | | | **GP: Address:** | | | | | | | Click or tap here to enter text. | | | | | | | | | | | | | | | | **Post code**: Click or tap here to enter text. | | | | |

**Thank You! Please send your completed referral to** [**add-tr.Cleftref@nhs.net**](mailto:add-tr.Cleftref@nhs.net)

**Please call the cleft office on 01223 596272 (Option 1) - To notify the office there is a referral**

**Diagnosis**

Please indicate with a tick the most appropriate diagnosis (you may need to tick more than one):

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Cleft lip +/- alveolus |  | Unilateral Cleft lip & palate | | |  | Bilateral cleft lip & palate |
| Unilateral Lip | | Complete Unilateral Lip and Palate | | | | Complete Bilateral Lip and Palate | |
|  | Micrognathia | | |  | Cleft of hard and soft palate | | |
| File0007 | | | |  | | | |
|  | Cleft of soft palate | | |  | Submucous Cleft palate | | |
|  | | | | Submucous Cleft Palate | | | |