37460

Submission: ☐ First ☐ Further information

Reporter

Reporter Last name

Reporter First name

Name of the Hospital / Practice

Postal code

Reporter Telephone

Town/City

Patient

Patient AVS/AHV Number

Date of birth

D D - M M - Y Y Y Y

Patient Last Name

Patient First name

Sex: ☐ male ☐ female

Town/City

Postal code

Cleft details

L A H S H A L

Right **Left**

. : no lesion
*: forme fruste cleft lip, alveolar notch, bifid uvula
lower case (l-a-h-s-h-a-l): incomplete cleft
CAPITAL CASE: (L-A-H-S-H-A-L): complete cleft

Simonart: ☐ ☐

Lip: ☐ c ☐ i ☐ c ☐ i

Type of cleft: c = complete, i = incomplete

Alveolus: ☐ c ☐ i ☐ c ☐ i

Hard palate: ☐ c ☐ i

Soft palate: ☐ c ☐ i

Vomer attached to hard palate: ☐ yes ☐ no

Submucous Cleft: ☐ yes ☐ no

No cleft, but velopharyngeal insufficiency: ☐ yes ☐ no

Cleft summary: __________

Pierre Robin: ☐ yes ☐ no

If cleft is part of a syndrome, name: __________

Other anomalies

Craniofacial area: ☐ yes ☐ no

Eye abnormalities: ☐ yes ☐ no

Cardiovascular system: ☐ yes ☐ no

Respiratory system: ☐ yes ☐ no

Renal system: ☐ yes ☐ no

Skeletal system: ☐ yes ☐ no

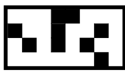
Details or other findings: __________

Consent signed: ☐

Date

D D - M M - Y Y Y Y

Thank you for your help! Please send copy of ALL the pages of this form and of the signed consent by fax to 022.372.50.85 or by mail to the following address:
Registre Suisse FLMP, Plate-forme de recherche - Hôpital des enfants - 6, rue Willy Donzé - 1211 GENEVE


37460

Submission: ☐ First ☐ Further information

Mother

Date of birth: __ __ - __ __ - __ __ __ __ (D D - M M - Y Y Y Y)

Occupation: ____

Does mum have a cleft: ☐ yes ☐ no

Maternal family history of clefts: ☐ yes ☐ no

History of miscarriages: ☐ yes ☐ no

Pregnancy

Residence during the first trimester of pregnancy

City: ____

Country: ____ – Postal code: ____

Gestation: __ __ Weeks (40 = full term)

Birth weight: __ __ __ __ g

Pre-natal diagnosis: ☐ yes ☐ no

Twins: ☐ yes ☐ no

Antenatal history of:

Medications: ☐ yes ☐ no

Smoking: ☐ yes ☐ no

Folic Acid: ☐ yes ☐ no

Alcohol consumption: ☐ yes ☐ no

Vitamins: ☐ yes ☐ no

Drug abuse: ☐ yes ☐ no

Illness: ☐ yes ☐ no

Trauma: ☐ yes ☐ no

Operations: ☐ yes ☐ no

Details: ____

Father

Date of birth: __ __ - __ __ - __ __ __ __ (D D - M M - Y Y Y Y)

Occupation: ____

Does dad have a cleft: ☐ yes ☐ no

Paternal family history of clefts: ☐ yes ☐ no

Family

Congenital anomalies among relatives: ☐ yes ☐ no

Details: ____

____

Number of other children of this couple

With a cleft: ☐

Without a cleft: ☐

Number of children from previous relationships

	Mother	Father
With a cleft:	☐	☐
Without a cleft:	☐	☐

Consent signed: ☐

Date: __ __ - __ __ - __ __ __ __ (D D - M M - Y Y Y Y)

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