



37460

Submission:  First Further information

1 / 2

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

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 cleftSimonart:  Lip:  c  i  c  iAlveolus:  c  i  c  iHard palate:  c  iSoft palate:  c  iVomer attached to hard palate:  yes  noSubmucous Cleft:  yes  noNo cleft, but velopharyngeal insufficiency:  yes  no

Type of cleft: c = complete, i = incomplete

Cleft summary: \_\_\_\_\_

Pierre Robin:  yes  no

If cleft is part of a syndrome, name: \_\_\_\_\_

Other anomalies

Craniofacial area:  yes  noRespiratory system:  yes  noEye abnormalities:  yes  noRenal system:  yes  noCardiovascular system:  yes  noSkeletal system:  yes  no

Details or other findings: \_\_\_\_\_

Consent signed: 

Date

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

<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<small>D</small>	<small>D</small>		<small>M</small>	<small>M</small>		<small>Y</small>	<small>Y</small>	<small>Y</small>	<small>Y</small>

Occupation

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Does mum have a cleft:  yes  noMaternal family history of clefts:  yes  noHistory of miscarriages:  yes  no

Pregnancy

Residence during the first trimester of pregnancy

City

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Country

Postal code

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Gestation  Weeks (40 = full term)Birth weight  gPre-natal diagnosis:  yes  noTwins:  yes  no**Antenatal history of:**Medications:  yes  noSmoking:  yes  noFolic Acid:  yes  noAlcohol consumption:  yes  noVitamins:  yes  noDrug abuse:  yes  noIllness:  yes  noTrauma:  yes  noOperations:  yes  no

Details: \_\_\_\_\_

Father

Date of birth

<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<small>D</small>	<small>D</small>		<small>M</small>	<small>M</small>		<small>Y</small>	<small>Y</small>	<small>Y</small>	<small>Y</small>

Occupation

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Does dad have a cleft:  yes  noPaternal family history of clefts:  yes  no

Family

Congenital anomalies among relatives:  yes  no

Details: \_\_\_\_\_

Number of other children  
of this coupleNumber of children from  
previous relationships

Mother

Father

With a cleft: With a cleft: Without a cleft: Without a cleft: Consent signed: 

Date

<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<small>D</small>	<small>D</small>		<small>M</small>	<small>M</small>		<small>Y</small>	<small>Y</small>	<small>Y</small>	<small>Y</small>

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