



37460

Submission: First Further information

Reporter

Reporter Last name

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Reporter First name

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Name of the Hospital / Practice

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Postal code

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Reporter Telephone

			-											
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Town/City

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Patient

Patient AVS/AHV Number

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Date of birth

				-					-								
<i>D</i>	<i>D</i>				<i>M</i>	<i>M</i>				<i>Y</i>	<i>Y</i>	<i>Y</i>	<i>Y</i>				

Patient Last Name

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Patient First name

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 Sex: male
 female

Town/City

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Postal code

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Cleft details

L A H S H A L

Right

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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 i

Type of cleft: c = complete, i = incomplete

Alveolus: c i c iHard palate: c iVomer attached to hard palate: yes noSoft palate: c iSubmucous Cleft: yes noNo 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 noRespiratory system: yes noEye abnormalities: yes noRenal system: yes noCardiovascular system: yes noSkeletal system: yes no

Details or other findings: _____

Consent signed:

Date

				-					-								
<i>D</i>	<i>D</i>				<i>M</i>	<i>M</i>				<i>Y</i>	<i>Y</i>	<i>Y</i>	<i>Y</i>				

Thank you for your help! Please send copy of ALL the pages of this form and of the signed consent by fax to 022.382.50.85 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"/>
<i>D</i>	<i>D</i>		<i>M</i>	<i>M</i>		<i>Y</i>	<i>Y</i>	<i>Y</i>	<i>Y</i>

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"/>	<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"/>
<i>D</i>	<i>D</i>		<i>M</i>	<i>M</i>		<i>Y</i>	<i>Y</i>	<i>Y</i>	<i>Y</i>

Occupation

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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"/>
<i>D</i>	<i>D</i>		<i>M</i>	<i>M</i>		<i>Y</i>	<i>Y</i>	<i>Y</i>	<i>Y</i>

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