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

|  |  |
| --- | --- |
| **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**

**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 |