HSC Health and Social Care

Record Book

Cleft lip and Palate Service

Child's name:

Date of birth:

Weight:

Height:

Cleft type:

Cleft Nurse Specialist: _____

Contact details: _____

Date of first appointment with Cleft Nurse Specialist

_____

Cleft Coordinator: _____

Contact details: _____

Cleft Surgeon: _____

Date of lip repair: _____

Weight: _____

Height: _____

Length of hospital stay: _____

Any other comments/ observations: _____

_____

Date of (first) palate repair: _____

Weight: _____

Height: _____

Length of hospital stay: _____

Any other comments/ observations: _____

_____

Date of (second) palate repair (if required): _____

Weight: _____

Height: _____

Length of hospital stay: _____

Any other comments/ observations: _____

_____

Date of baby clinic: _____

Name of Speech and Language Therapist:

_____

Contact details: _____

Speech sounds present: _____

Name of Clinical Psychologist: _____

Contact details: _____

Name of Dental Consultant: _____

Contact details: _____

Date of 18-24month assessment: _____

Speech sounds present: _____

Language ability: _____

Date of 30-36month assessment: _____

Speech sounds present: _____

Language ability: _____

Date of any other assessments:

Videofluoroscopy (X-ray): _____

Nasendoscopy: _____

Type of speech surgery (if indicated following X-ray/ Nasendoscopy):

- ☐ Palate re-repair
- ☐ Fistula repair
- ☐ Pharyngoplasty

Date of speech surgery: _____

Weight _____

Height _____

Length of hospital stay _____

Any other comments/ observations:

_____

Date of 5 year assessment: _____

Any other comments

Hearing: _____

Speech: _____

Dental: _____

Psychology: _____

Date of 7 year assessment: _____

Any other comments

Hearing: _____

Speech: _____

Dental: _____

Psychology: _____

Date of Alveolar Bone Graft Planning Clinic:

_____

Date of Alveolar Bone Graft Operation: _____

Weight: _____

Height: _____

Hip: Right/ Left _____

Length of hospital stay: _____

Any other comments/ observations:

_____

Date of 10 year assessment: _____

Hearing: _____

Speech: _____

Dental: _____

Psychology: _____

Date of 15 year assessment: _____

Hearing: _____

Speech: _____

Dental: _____

Psychology: _____

Date of any other procedures: _____

Date of discharge from Cleft Lip and Palate Service:

_____

After you have been discharged, you can ask for a re-referral to the Cleft Lip and Palate team via your GP if you have any concerns regarding your cleft.

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