

- 1 Eingabe validieren; nur korrekte Eingaben zulassen. Beispiel: Datum/E-Mail/Telefonnummern.
- 2 Dropdown-Felder für einfache Auswahl.
- 3 Felder ein-/ausblenden durch klicken auf «None».

Patient Information

General Information

Male Female

Date of Birth (dd/mm/yyyy):

1

Surname/Last Name:

Given Name/First Name:

Number of Siblings:

2

Number of Clefts in the Family:

Town/Village/City:

Provinces Iraq:

Country:

Distance to the Cleft-Centre (in km):

School Education:

Profession:

None

3

Denomination:

E-Mail Address:

None

1

Mobile Phone:

 + 9 6 4

None

1

Parent/Guardian Information

Surname/Last Name:

None

Given Name/First Name:

None

Relationship with the patient:

Mother Father Grandparent Sibling Friend Other

How did the patient hear about Cleft-Kinder-Hilfe Schweiz?

NGO Hospital Radio TV Newspaper Flyer Cooperation Partner

Other (Name of the Referring Organization):

Diagnosis

Patient Height (in cm): _____

Patient Weight (in kg): _____

Did the patient have any lip/palate surgery before this evaluation?

Yes No

If yes, pick the type of surgery the patient had:

Cleft Lip Surgery Cleft Palate Surgery Cleft Lip and Palate Surgery

Lip

| Type of Cleft Lip | Patient's Left | Patient's Right |
|-------------------|--------------------------|--------------------------|
| 1 No Cleft | <input type="checkbox"/> | <input type="checkbox"/> |
| 2 Incomplete | <input type="checkbox"/> | <input type="checkbox"/> |
| 3 Complete | <input type="checkbox"/> | <input type="checkbox"/> |

Alveolus

| Type of Cleft Lip | Patient's Left | Patient's Right |
|-------------------|--------------------------|--------------------------|
| 1 No Cleft | <input type="checkbox"/> | <input type="checkbox"/> |
| 2 Incomplete | <input type="checkbox"/> | <input type="checkbox"/> |
| 3 Complete | <input type="checkbox"/> | <input type="checkbox"/> |

Hard Palate

| Type of Cleft Palate | Patient's Left | Patient's Right |
|----------------------|--------------------------|--------------------------|
| 1 No Cleft | <input type="checkbox"/> | <input type="checkbox"/> |
| 2 Incomplete | <input type="checkbox"/> | <input type="checkbox"/> |
| 3 Complete | <input type="checkbox"/> | <input type="checkbox"/> |

Soft Palate

| Type of Cleft Palate | Patient's Left | Patient's Right |
|----------------------|--------------------------|--------------------------|
| 1 No Cleft | <input type="checkbox"/> | <input type="checkbox"/> |
| 2 Incomplete | <input type="checkbox"/> | <input type="checkbox"/> |
| 3 Complete | <input type="checkbox"/> | <input type="checkbox"/> |

Are there additional craniofacial deformities?

Yes No Don't know

1

If yes, please describe the type of deformity:

1 Felder anhand Abhängigkeiten ein- bzw. ausblenden.

Intervention Information

Surgical Treatment

Date of Admission (dd/mm/yyyy):

| | | | | | | | |
|--|--|--|--|--|--|--|--|
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|--|--|--|--|--|--|--|--|

Date of Surgical Treatment (dd/mm/yyyy):

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|--|--|--|--|--|--|--|--|
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|--|--|--|--|--|--|--|--|

Date of Discharge (dd/mm/yyyy):

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| | | | | | | | |
|--|--|--|--|--|--|--|--|

Name of Surgeon 1:

Name of Surgeon 2:

Name of Anaesthesiologist:

Name of Anaesthesiologist Assistant:

Anesthesia Method:

- General
- Local

Type of Operation:

- Primary Lip/Nose Unilateral Repair
- Primary Lip/Nose Bilateral Repair
- Primary Cleft Palate Repair
- Fistula Repair
- Secondary Cleft Palate
- Lip/Nose Revision
- Alveolar Bone Graft
- Other (specify):

Were there any complications, injury, or patient mortality?

- Yes
- No

If yes, did the complications result in patient death or serious physical/psychological injury?

- Yes
- No

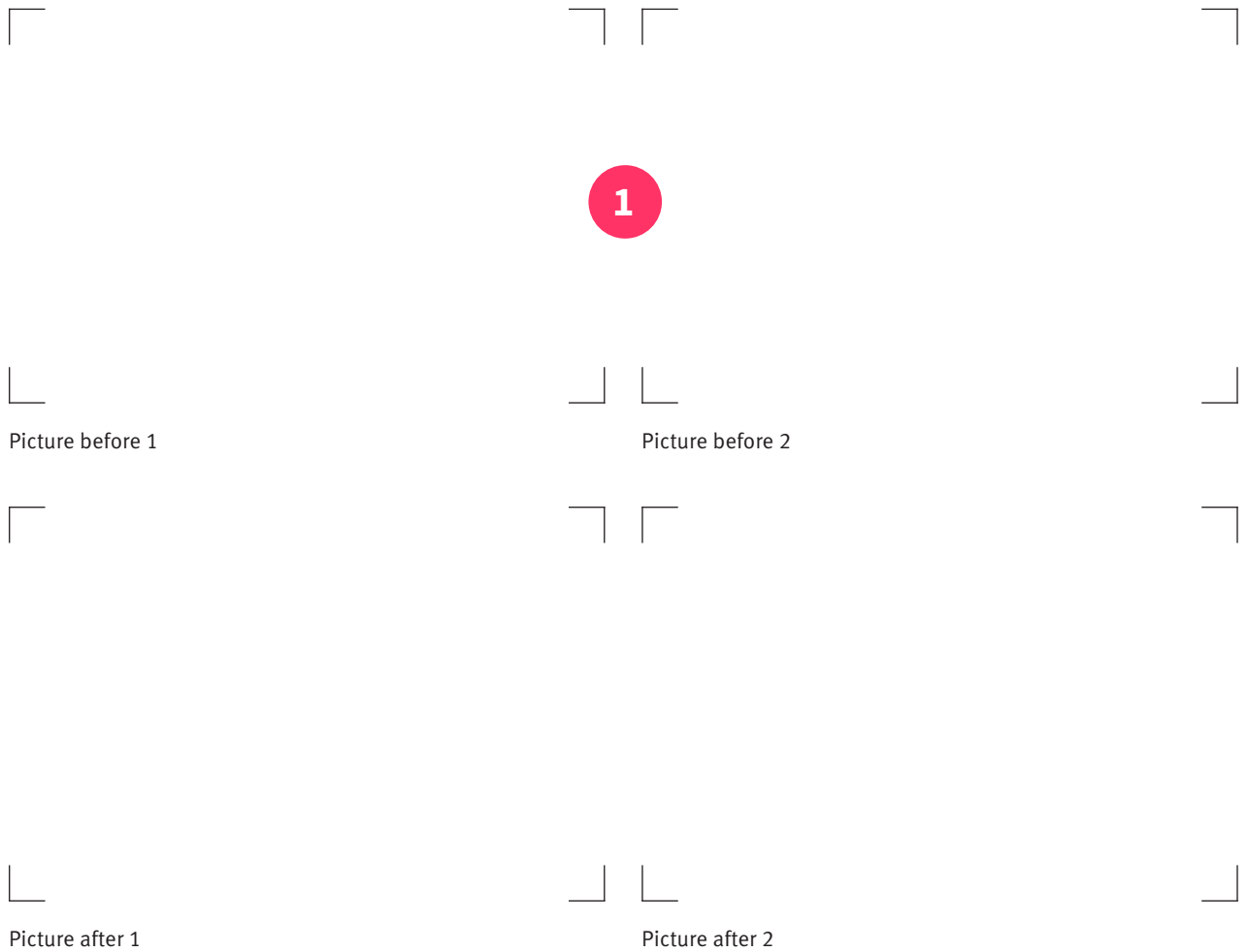
If no, please indicate the type of complication:

| |
|--|
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|--|

Additional comments on intervention (optional):

| |
|--|
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Pictures



- 1 Bilder ab Computer standrechtig ins PDF einfügen.
- 2 Dokument simpel per Knopfdruck speichern/drucken.
- 3 Dokument sperren: Felder können danach nicht mehr bearbeitet werden.

2

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