

Cleft Lip and Palate Referral Form



Child Youth & Family Health Rehab Services

Queen Alexandra Centre for Children's Health

2400 Arbutus Road Victoria, BC V9B 3A1

Phone: 250-519-6763 or 250-519-6967 Fax: 250-519-6918

Referral date: / /

MRN:

CLIENT INFORMATION		
Surname:	First Name:	Middle Name:
PHN:	DOB:	Gender: <input type="checkbox"/> F <input type="checkbox"/> M
Parent/Legal Guardian name:		
Address:		
City:	Province:	Postal code:
Home #:	Cell #:	Email:
Spoken languages: <input type="checkbox"/> English <input type="checkbox"/> Other:		Interpreter required: <input type="checkbox"/> Y <input type="checkbox"/> N
Client/family aware of the referral: <input type="checkbox"/> Y <input type="checkbox"/> N		
REFERRAL SOURCE		
Name:	Agency:	
Tel #:	Fax #:	Email:
Relationship to client:		
CLEFT INFORMATION		
Prenatal/Infant Referral:		Suspected Submucosal Cleft Referral:
<input type="checkbox"/> Prenatal Diagnosis	<input type="checkbox"/> Cleft Lip <input type="checkbox"/> Cleft Palate	<input type="checkbox"/> Physical confirmation by ENT
Weeks Gestation	<input type="checkbox"/> Unilateral <input type="checkbox"/> Bilateral	<input type="checkbox"/> Resonance confirmation by SLP
Other details:		
Other medical conditions:		
SOCIAL INFORMATION		
<input type="checkbox"/> No concerns	<input type="checkbox"/> Followed by social worker	<input type="checkbox"/> Financial/housing concerns <input type="checkbox"/> Family stressors
<input type="checkbox"/> Emotional distress	<input type="checkbox"/> Child protection concerns	<input type="checkbox"/> Child in foster care <input type="checkbox"/> Family strengths
Other / comments:		
MEDICAL SUPPORT	NAME AND AGENCY	CONTACT INFORMATION
Family physician		
Pediatrician		
Midwife or OB/GYN		
Dietitian		
Occupational therapist		
SLP		
Social worker		
Other:		

INCLUDE ALL APPLICABLE AND RELEVANT DOCUMENTATION