PRESURGICAL ORTHOPAEDIC TREATMENT

A1 ID Number _____

A2 Name _____

A3 Date of Birth dd/mm/yy ☐☐/☐☐/☐☐

A4 Hospital Number _____

A5 Today's date ☐☐/☐☐/☐☐

Place for Cleft identification sticker if available

B1 Did the child have a plate fitted as a baby?

☐1 Yes
☐2 No
☐3 Not recorded

B2 Type of plate:

☐1 Feeding plate
☐2 Active pre-surgical appliance
☐3 Passive pre-surgical appliance
☐4 B2A Other, please specify _____
☐5 Don't know

B3 Was extra-oral strapping fitted?

☐1 Yes
☐2 No
☐3 Not recorded

B4 Where was the plate fitted (which hospital)? _____

B5 Who fitted the plate? _____

B6 Date fitted (dd/mm/yy) ☐☐/☐☐/☐☐

B7 Date removed (dd/mm/yy) ☐☐/☐☐/☐☐

B8 Did the child continue with the plate until the time of palate repair?

☐1 Yes
☐2 No
☐3 Not recorded

AUDIT CLINIC DATA

B9 Was impressions obtained?

☐ 1 Yes

☐ 2 No

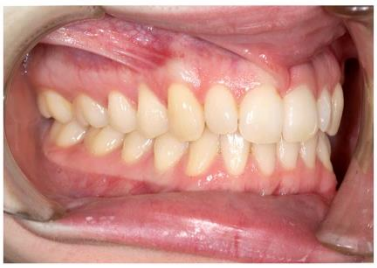
B10 Was intra oral photographs obtained?

☐ 1 Yes (if yes, please tick what views obtained below)

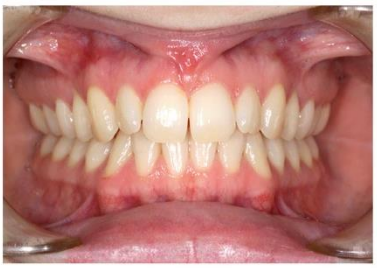
☐ 2 No

B11	Teeth right oblique (B08)	Yes	☐ 1	No	☐ 2
B12	Teeth AP (B09)	Yes	☐ 1	No	☐ 2
B13	Teeth left oblique (B10)	Yes	☐ 1	No	☐ 2
B14	Palate (hard) (B11)	Yes	☐ 1	No	☐ 2
B15	Teeth upper arch (mirror) (B12)	Yes	☐ 1	No	☐ 2
B16	Teeth overjet (B13)	Yes	☐ 1	No	☐ 2

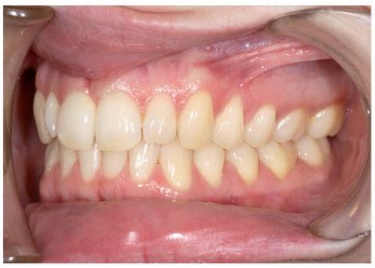
Intra-oral views **Magnification ratio 1:2**



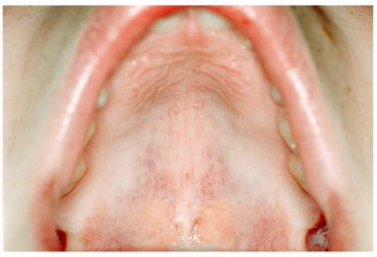
B08



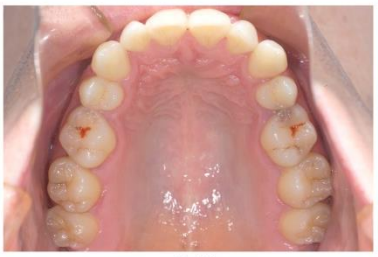
B09



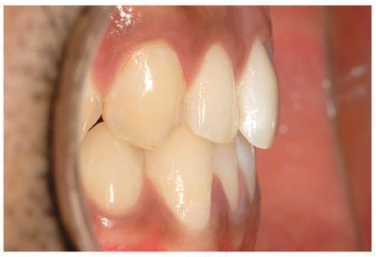
B10



B11



B12



B13

Thank you for filling this in – please state your

C1 Name: _____

C2 Designation: _____

C3 Email: _____

C4 Contact number: _____

C5 Any additional information that you think would be helpful is most welcome.

_____

_____