A. COMPLETION OF SURGICAL DETAILS

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

B. SURGICAL SEQUENCE OF PRIMARY REPAIR

B1 Evidence (Tick one relevant box)

Definite - recorded in Notes ☐ 1 | **Probable -** eg: Historical, Interview with surgeon ☐ 2 | **None** ☐ 3

	B2 Surgical sequence (Tick one relevant box)	**Date of operation** (dd/mm/yy)
☐ A	1. Lip *(without any closure of hard palate)*	☐☐/☐☐/☐☐
	2. Hard palate + soft palate	☐☐/☐☐/☐☐
☐ B	1. Lip and anterior hard palate	☐☐/☐☐/☐☐
	2. Posterior hard palate + soft palate	☐☐/☐☐/☐☐
☐ C	1. Lip + soft palate	☐☐/☐☐/☐☐
	2. Hard palate	☐☐/☐☐/☐☐
☐ D	1. Soft palate	☐☐/☐☐/☐☐
	2. Lip + hard palate	☐☐/☐☐/☐☐
☐ E	1. Lip adhesion	☐☐/☐☐/☐☐
	2. Lip repair	☐☐/☐☐/☐☐
	3. Palate repair	☐☐/☐☐/☐☐
☐ F	1. Lip and palate repair	☐☐/☐☐/☐☐
☐ G	1. Other *(please specify)*	____________________

PRIMARY LIP REPAIR

B3. PRIMARY LIP REPAIR

A Information available Yes ☐ 1 No ☐ 2

Lip adhesion

B. Was lip adhesion undertaken? Yes ☐ 1 No ☐ 2 Not recorded ☐ 3

C. Date of lip adhesion procedure ☐☐/☐☐/☐☐ Not recorded ☐ 1

D. Surgeons name: ______________________________ 1

E. Hospital: ______________________________ 1

F. Speciality (Tick one box)

☐ 1 Plastic surgery

☐ 2 Oral/maxillofacial surgery

☐ 3 Paediatric surgery

☐ 4 Other , please specify ______________________________

☐ 5 Not known

G. Grade

☐ 1 Consultant

☐ 2 Senior Registrar (alone)

☐ 3 Senior Registrar (supervised)

☐ 4 Registrar (alone)

☐ 5 Registrar (supervised)

☐ 6 SHO (alone)

☐ 7 SHO (supervised)

☐ 8 Associate specialist

☐ 9 Staff grade

☐ 10 Not known

Preoperative orthopaedics lip

B4A. Was Preoperative orthopaedics used – until lip repair?

- ☐ 1 Yes, active with strapping
- ☐ 2 Yes, passive with strapping
- ☐ 3 Yes, active no strapping
- ☐ 4 Yes, feeding plate only
- ☐ 5 No
- ☐ 6 Not recorded

Primary Lip Repair

B. Date of lip repair ☐☐/☐☐/☐☐ Not recorded ☐ 1

C. Surgeons ____

D. Hospital: ____

E. Speciality (Tick one box)

- ☐ 1 Plastic surgery
- ☐ 2 Oral/maxillofacial surgery
- ☐ 3 Paediatric surgery
- ☐ 4 Other , please specify ________________________________
- ☐ 5 Not known

F. Grade

- ☐ 1 Consultant
- ☐ 2 Senior Registrar (alone)
- ☐ 3 Senior Registrar (supervised)
- ☐ 4 Registrar (alone)
- ☐ 5 Registrar (supervised)
- ☐ 6 SHO (alone)
- ☐ 7 SHO (supervised)
- ☐ 8 Associate specialist
- ☐ 9 Staff grade
- ☐ 10 Not known

Primary Lip Repair

B5. Details of Primary Lip Repair Operation *(Please tick Yes or No or Not recorded)*

A. Magnification (Loupes) Yes ☐1 No ☐2 Not recorded ☐3

B. Microscope Yes ☐1 No ☐2 Not recorded ☐3

C. Primary nasal correction Yes ☐1 No ☐2 Not recorded ☐3

D. Details: ____________________

E. Muscle dissection as separate layer Yes ☐1 No ☐2 Not recorded ☐3

F. Details: ____________________

G. Elevation of periosteum from anterior maxilla Yes ☐1 No ☐2 Not recorded ☐3

H. Details: ____________________

I. Vomerine flap Yes ☐1 No ☐2 Not recorded ☐3

J. Details: ____________________

K. Was another procedure undertaken at the same time? Yes ☐1 No ☐2 Not recorded ☐3

L .Details: ____________________

B6. Details of skin closure technique

A. Glue ☐1 Sutures non-reabsorbable ☐2 Steristrips ☐3

B. Other, please specify ____________________

B7. Complications following lip repair

A. Surgical Yes ☐1 No ☐2 Not recorded ☐3

B. Details: ____________________

C. Anaesthetic Yes ☐1 No ☐2 Not recorded ☐3

D. Details: ____________________

E. Time as in-patient: ☐☐☐ Days Not known ☐3

B8A. Antibiotics at time of closure of lip Yes ☐1 No ☐2

PRIMARY HARD PALATE REPAIR

B9. Primary hard palate repair *(Please tick Yes or No or Not recorded)*

A. Information available Yes ☐1 No ☐2 Not recorded ☐3

Preoperative orthopaedics palate

B9B. Was Preoperative orthopaedics continued until palate repair?

Yes ☐1 No ☐2 No presurgical orthopaedics used ☐3 Not recorded ☐4

Hard Palate Operation

B10. Date of palate repair ☐☐/☐☐/☐☐ Not recorded ☐1

A. Surgeons name: ______________________________1

B. Hospital: ______________________________1

C. Speciality (Tick one box)

☐1 Plastic surgery

☐2 Oral/maxillofacial surgery

☐3 Paediatric surgery

☐4 Other , please specify ______________________________

☐5 Not known

D. Grade

☐1 Consultant

☐2 Senior Registrar (alone)

☐3 Senior Registrar (supervised)

☐4 Registrar (alone)

☐5 Registrar (supervised)

☐6 SHO (alone)

☐7 SHO (supervised)

☐8 Associate specialist

☐9 Staff grade

☐10 Not known

E. Time as in-patient: ☐☐☐ Days Not known ☐1

Hard Palate Operation

B11. Details of Palate Operation *(Please tick Yes or No or Not recorded)*

A. Magnification (Loupes)	Yes ☐ 1	No ☐ 2	Not recorded ☐ 3
B. Microscope	Yes ☐ 1	No ☐ 2	Not recorded ☐ 3
C. Headlights used	Yes ☐ 1	No ☐ 2	Not recorded ☐ 3
D. Muscle repair (Intravelar veloplasty)	Yes ☐ 1	No ☐ 2	Not recorded ☐ 3

E. Details: ______________________________

____

____

B12. Antibiotics at time of closure of palate Yes ☐ 1 No ☐ 2

B13. Complications following palate repair

A. Surgical	Yes ☐ 1	No ☐ 2	Not recorded ☐ 3

Details: ______________________________ 4

B. Anaesthetic	Yes ☐ 1	No ☐ 2	Not recorded ☐ 3

Details: ______________________________ 4

C. Time as in-patient: ☐☐☐ Days Not known ☐ 1

PRIMARY SOFT PALATE OPERATION

B14 Primary Soft Palate Operation Yes ☐1 No ☐2

B15. Date of palate repair ☐☐/☐☐/☐☐ Not recorded ☐1

A. Surgeons name: ______________________________1

B. Hospital: ______________________________1

C. Speciality (Tick one box)

☐1 Plastic surgery

☐2 Oral/maxillofacial surgery

☐3 Paediatric surgery

☐4 Other , please specify ______________________________

☐5 Not known

D. Grade

☐1 Consultant

☐2 Senior Registrar (alone)

☐3 Senior Registrar (supervised)

☐4 Registrar (alone)

☐5 Registrar (supervised)

☐6 SHO (alone)

☐7 SHO (supervised)

☐8 Associate specialist

☐9 Staff grade

☐10 Not known

E. Time as in-patient: ☐☐☐ Days Not known ☐1

Soft Palate Operation

B16. Details of Palate Operation *(Please tick Yes or No or Not recorded)*

	Yes	No	Not recorded
A. Magnification (Loupes)	☐1	☐2	☐3
B. Microscope	☐1	☐2	☐3
C. Headlights used	☐1	☐2	☐3
D. Muscle repair (Intravelar veloplasty)	☐1	☐2	☐3

E. Details: ______________________________

____

B17. Palate dissection: *(Tick one each of * and #. If Wardill-Kilner is ticked, tick also one of ø)*

	Yes	No	Not recorded
A*extra-periosteal	☐ 1	☐ 2	☐ 3
B*subperiosteal	☐ 1	☐ 2	☐ 3
C#Langenbeck	☐ 1	☐ 2	☐ 3
D#Wardill-Kilner	☐ 1	☐ 2	☐ 3
ølong flaps 1	☐ 1	☐ 2	☐ 3
ø3 flap 2	☐ 1	☐ 2	☐ 3
ø4 flap 3	☐ 1	☐ 2	☐ 3
E#no flaps	☐ 1	☐ 2	☐ 3
F#Delaire	☐ 1	☐ 2	☐ 3
G#Other (please give details below)	☐ 1	☐ 2	☐ 3

G1. Details: ____

____

B18. Antibiotics at time of closure of palate Yes ☐ 1 No ☐ 2

B19. Complications following palate repair

A. Surgical Yes ☐ 1 No ☐ 2 Not recorded ☐ 3

Details: ____ 4

B. Anaesthetic Yes ☐ 1 No ☐ 2 Not recorded ☐ 3

Details: ____ 4

C. Time as in-patient: ☐☐☐ Days Not known ☐ 1

B20. SECONDARY PROCEDURES (EXCLUDING FIRST ALVEOLAR BONE GRAFT)

A. Information available ☐ 1 Yes ☐ 2 No ☐ 3 Incomplete

A1. If incomplete, please give date from which information is available ☐☐/☐☐/☐☐ A

Details of secondary procedures

Lip revision	**Date of operation**	**Sequence of operations***
B1. 1st	☐☐/☐☐/☐☐ A	____________ B
Details: ____________________________ C		
B2. 2nd	☐☐/☐☐/☐☐ A	____________ B
Details: ____________________________ C		
B3. Subsequent	☐☐/☐☐/☐☐ A	____________ B
Details: ____________________________ C		

Nasal revision	**Date of operation**	**Sequence of operations***
C1. 1st	☐☐/☐☐/☐☐ A	____________ B
Details: ____________ C		
C2. 2nd	☐☐/☐☐/☐☐ A	____________ B
Details: ____________ C		
C3. Subsequent	☐☐/☐☐/☐☐ A	____________ B
Details: ____________ C		
Fistula closure	**Date of operation**	**Sequence of operations***
D1. 1st	☐☐/☐☐/☐☐ A	____________ B
Details: ____________ C		
D2. 2nd	☐☐/☐☐/☐☐ A	____________ B
Details: ____________ C		
D3. Subsequent	☐☐/☐☐/☐☐ A	____________ B
Details: ____________ C		
Secondary velopharyngeal surgery	**Date of operation**	**Sequence of operations***
E1. Palate re-repair	☐☐/☐☐/☐☐ A	____________ B
Details: ____________ C		
E2. Pharyngoplasty	☐☐/☐☐/☐☐ A	____________ B
Details: ____________ C		
E3. Other: ____________ A	☐☐/☐☐/☐☐ B	____________ C
Details: ____________ D		
Other procedures (not including ENT)	**Date of operation**	**Sequence of operations***
F1. Other: ____________ A	☐☐/☐☐/☐☐ B	____________ C
Details: ____________ D		
F2. Other: ____________ A	☐☐/☐☐/☐☐ B	____________ C
Details: ____________ D		

***N.B:** *Number the sequence of secondary operations. If more than one procedure was performed at one operation (probably under a general anaesthetic), it is the operation which should be numbered, not the procedure. If a procedure was performed more than once, it should be numbered for each occasion. The highest number in the "Sequence of operations" column will therefore give the total number of general anaesthetics given for secondary operations.*

C ASSESSMENT OF SURGICAL DETAILS

C1. ID Number ____________________________

C2. Name ____________________________

C3. Date of Birth dd/mm/yy ☐☐/☐☐/☐☐

C4. Hospital Number ____________________________

C5. Today's date ☐☐/☐☐/☐☐

Place for Cleft identification sticker if available

D1. LAHSHAL Classification: ____

D2. If complete lip, presence of Simonart's bands? (if yes, indicate left, right or bilateral)

No ☐ 1 Yes ☐ 2 Left ☐ 3 Right ☐ 4 Bilateral ☐ 5

D3. Lip

A. Lip length

Significant shorter ☐ 1 Minimally short ☐ 2 Equal ☐ 3 Longer ☐ 4

B. Vermillion

Notched/deficient ☐ 1 Balanced/equal ☐ 2 Too full/bulging ☐ 3

C. Cupid's bow

Poor ☐ 1 Satisfactory ☐ 2 Good ☐ 3 Very good ☐ 4

D. Scar quality

Poor ☐ 1 Satisfactory ☐ 2 Good ☐ 3 Very good ☐ 4

E. Function – on smiling

Symmetrical/equal length ☐ 1 Asymmetrical/shortens ☐ 2

F. Function – on pouting

Symmetrical ☐ 1 Asymmetrical ☐ 2

D4. Nose

A. Frontal view appearance/symmetry

Poor ☐ 1 Satisfactory ☐ 2 Good ☐ 3 Very good ☐ 4

B. Inferior view appearance/symmetry

Poor ☐ 1 Satisfactory ☐ 2 Good ☐ 3 Very good ☐ 4

D5. Palate

A. Lateral release incisions Yes ☐ 1 No ☐ 2

B. Previous secondary speech surgery (If yes, indicate accordingly)

No ☐ 1 Yes ☐ 2 Re-repair ☐ 3 Flap ☐ 4 Pharyngoplasty ☐ 5

C. Nasal Regurgitation Post Palate Repair No ☐ 1 Yes – solids ☐ 2 Yes – liquids ☐ 3 Yes – both ☐ 4

D6A. Is there a fistula(e) present?

☐1 Yes ☐2 No

D6B. If Yes, does the fistula cause problems?

☐1 Yes ☐2 No

D6C. If yes, describe problem

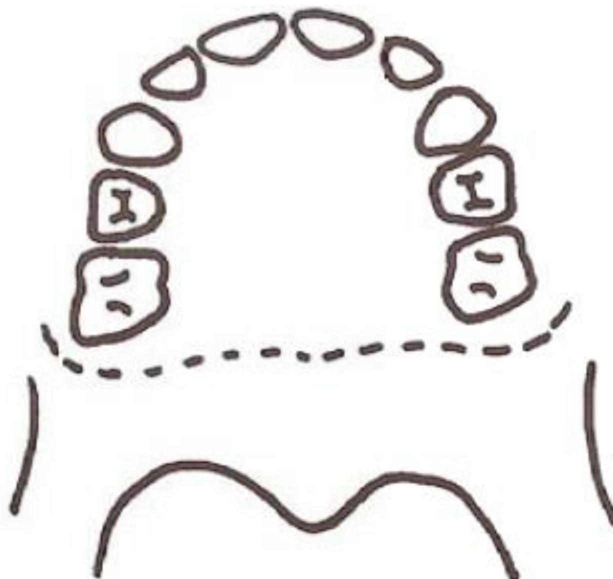
☐1 Food impacted in fistula
☐2 Liquids escape through fistula
☐3 Increased nasal discharge

D6D. Other problem: ______________________________

Give details of site and size of fistula(e)

	Site(s)*A	Maximum width (mm) B
D7. Uvula		
D8. Soft palate		
D9. Soft/hard palate		
D10. Hard palate		
D11. Labial sulcus		
D12. Buccal sulcus		

*** Please draw site and shape of fistula (e) on diagram below**



PLEASE TURNOVER →

D13A. Photos Cleft Lip available pre-op (infant)	Yes	☐ 1	No	☐ 2
D13C. Photos Cleft Palate available pre-op (infant)	Yes	☐ 1	No	☐ 2

D13B. Has 3D image been taken for this patient?	Yes	☐ 1	No	☐ 2

Thank you for filling this in – please state your

E1. Name: ____

E2. Designation: ____

E3. Email: ____

E4. Contact number: ____

E5. Any additional information that you think would be helpful is most welcome.

____

____

____