

MEASUREMENTS (MM)		MEASUREMENTS (MM)					
*Complete if no Study Model		27. Canthal Distance From	<table border="1"> <tr> <td>Right</td> <td>Left</td> </tr> <tr> <td><input type="text"/></td> <td><input type="text"/></td> </tr> </table>	Right	Left	<input type="text"/>	<input type="text"/>
		Right	Left				
<input type="text"/>	<input type="text"/>						
28. Columella Length - Start	<table border="1"> <tr> <td>Right</td> <td>Left</td> </tr> <tr> <td><input type="text"/></td> <td><input type="text"/></td> </tr> </table>	Right	Left	<input type="text"/>	<input type="text"/>		
Right	Left						
<input type="text"/>	<input type="text"/>						
19. Alveolar Cleft Transverse Width (Narrowest Point)*	<input type="text"/>	29. Alar Base Width - Start	<table border="1"> <tr> <td>Right</td> <td>Left</td> </tr> <tr> <td><input type="text"/></td> <td><input type="text"/></td> </tr> </table>	Right	Left	<input type="text"/>	<input type="text"/>
Right	Left						
<input type="text"/>	<input type="text"/>						
20. Alveolar Cleft AP Distance*	<input type="text"/>	30. Philtral Column Height	<table border="1"> <tr> <td>Right</td> <td>Left</td> </tr> <tr> <td><input type="text"/></td> <td><input type="text"/></td> </tr> </table>	Right	Left	<input type="text"/>	<input type="text"/>
Right	Left						
<input type="text"/>	<input type="text"/>						
21. Alveolar Cleft Transverse*	<input type="text"/>	31. Vermillion - Wet Dry junction Medial Element	<table border="1"> <tr> <td>Right</td> <td>Left</td> </tr> <tr> <td><input type="text"/></td> <td><input type="text"/></td> </tr> </table>	Right	Left	<input type="text"/>	<input type="text"/>
Right	Left						
<input type="text"/>	<input type="text"/>						
22. Alveolar Cleft Vertical*	<input type="text"/>	32. Vermillion Wet Dry (Lateral)	<table border="1"> <tr> <td>Right</td> <td>Left</td> </tr> <tr> <td><input type="text"/></td> <td><input type="text"/></td> </tr> </table>	Right	Left	<input type="text"/>	<input type="text"/>
Right	Left						
<input type="text"/>	<input type="text"/>						
23. Mid Hard Palate*	<input type="text"/>	33. Cupids Peak to Bow	<table border="1"> <tr> <td>Right</td> <td>Left</td> </tr> <tr> <td><input type="text"/></td> <td><input type="text"/></td> </tr> </table>	Right	Left	<input type="text"/>	<input type="text"/>
Right	Left						
<input type="text"/>	<input type="text"/>						
24. Hard Soft Palate Junction - Soft*	<input type="text"/>	34. Position of ANS Deviation from Midline (mm)	<table border="1"> <tr> <td>Right</td> <td>Left</td> </tr> <tr> <td><input type="text"/></td> <td><input type="text"/></td> </tr> </table>	Right	Left	<input type="text"/>	<input type="text"/>
Right	Left						
<input type="text"/>	<input type="text"/>						
25. Base of Uvula Width	<input type="text"/>	35. Columella Length	<table border="1"> <tr> <td>Right</td> <td>Left</td> </tr> <tr> <td><input type="text"/></td> <td><input type="text"/></td> </tr> </table>	Right	Left	<input type="text"/>	<input type="text"/>
Right	Left						
<input type="text"/>	<input type="text"/>						
26. Intertuberosity Width*	<input type="text"/>	36. Alar Base Width - End	<table border="1"> <tr> <td>Right</td> <td>Left</td> </tr> <tr> <td><input type="text"/></td> <td><input type="text"/></td> </tr> </table>	Right	Left	<input type="text"/>	<input type="text"/>
Right	Left						
<input type="text"/>	<input type="text"/>						

37. VOMER FLAP	<input type="checkbox"/> Yes <input type="checkbox"/> No If no, go straight to question 46	LIP REPAIR	
38. Complete	<input type="checkbox"/> Yes <input type="checkbox"/> No	46. Type of Repair	<input type="text"/>
39. Distal Relieving Incision	<input type="checkbox"/> Yes <input type="checkbox"/> No	47. White Roll Triangle	<input type="text"/>
40. Anterior Relieving Incision	<input type="checkbox"/> Yes <input type="checkbox"/> No	48. Vermillion Z or Triangle	<input type="text"/>
41. Layers Closed	<input type="checkbox"/> Vomer & Palatine <input type="checkbox"/> Vomer & Nasal	49. Buccal Sulcus Release	<input type="checkbox"/> Medial <input type="checkbox"/> None <input type="checkbox"/> Lateral
		50. Sub Periosteal Dissection	<input type="checkbox"/> Yes <input type="checkbox"/> No
42. Suture for Closure	<input type="text"/>	51. Alar Base Incision	<input type="checkbox"/> Yes <input type="checkbox"/> No
43. Tisseal	<input type="checkbox"/> Yes <input type="checkbox"/> No	52. Muscle Dissection	<input type="checkbox"/> Radical <input type="checkbox"/> None <input type="checkbox"/> Moderate
44. Periosteoplasty	<input type="checkbox"/> Yes <input type="checkbox"/> No	53. Muscle Score 1-3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
45. Turbinate Bone Graft	<input type="checkbox"/> Yes <input type="checkbox"/> No	54. Muscle Tension 1-3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3



NOSE	CLOSURE
55. Septal mucosal dissection <input type="checkbox"/> Right <input type="checkbox"/> Left	61. Nasal Floor <input type="text"/>
56. Septal Dissociation from ANS <input type="checkbox"/> Yes <input type="checkbox"/> No	62. Alar Base <input type="text"/>
57. Nasal Dissection - Lateral <input type="checkbox"/> Yes <input type="checkbox"/> No	63. Mucosa / Vermillion <input type="text"/>
58. Nasal Dissection - Medial <input type="checkbox"/> Yes <input type="checkbox"/> No	64. Muscle <input type="text"/>
59. Score of Nasal Correction <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	65. Skin <input type="text"/>
60. McCombs Dissection <input type="checkbox"/> Yes <input type="checkbox"/> No	66. McComb / Nasal <input type="text"/>

67. Surgical Complications	a) <input type="checkbox"/> Yes <input type="checkbox"/> No b) If yes, please specify: <input type="text"/>
68. Transfusions	a) <input type="checkbox"/> Yes <input type="checkbox"/> No b) If yes, please specify volume in mls: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>
69. Anaesthesia	a) Type: <input type="text"/> Hours Mins b) Length: <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> c) Complications: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/> c) If yes, please specify: <input type="text"/>
70. Analgesia	a) Pre op: <input type="checkbox"/> Yes <input type="checkbox"/> No ai) If yes, please specify: <input type="checkbox"/> paracetamol <input type="checkbox"/> morphine iv <input type="checkbox"/> fentanyl <input type="checkbox"/> morphine NCA b) Intra op: <input type="checkbox"/> Yes <input type="checkbox"/> No bi) If yes, please specify: <input type="checkbox"/> paracetamol <input type="checkbox"/> morphine iv <input type="checkbox"/> fentanyl <input type="checkbox"/> morphine NCA c) Post op: <input type="checkbox"/> Yes <input type="checkbox"/> No ci) If yes, please specify: <input type="checkbox"/> paracetamol <input type="checkbox"/> morphine iv <input type="checkbox"/> fentanyl <input type="checkbox"/> morphine NCA
71. Tranexamic Acid	<input type="checkbox"/> Yes <input type="checkbox"/> No
72. Steroids	<input type="checkbox"/> Yes <input type="checkbox"/> No
73. Other	<input type="text"/>

POST OP INSTRUCTIONS	
74. Antibiotics Regimen	<input type="checkbox"/> Nil <input type="checkbox"/> 24 hours post op <input type="checkbox"/> Other <input type="checkbox"/> On induction <input type="checkbox"/> 5-7 days post op
75. Antibiotics	<input type="text"/>
76. Arms	<input type="checkbox"/> Splints <input type="checkbox"/> Mittens <input type="checkbox"/> Nil
77. Nasal Splints	a) <input type="checkbox"/> Yes <input type="checkbox"/> No b) Size <input type="text"/> c) Brand <input type="text"/>
78. Review Arrangements	<input type="text"/>

Signature:

Date / /

Name:



18. continued....

DIAGRAM

