

PATIENT RECORD CONSENT DOCUMENT

The surgery _____ (*Name of Patient*) is about to receive is supported by The Smile Train. The Smile Train is an international children's charity working with doctors and hospitals to eradicate the prevalence of cleft lips and cleft palates.

The Smile Train maintains medical records on the patients undergoing surgery. These records include information such as: the names and addresses of patients and their parents, clinical diagnosis, other relevant medical health information, surgical procedures, and results. The records also include pictures of all patients taken before and after surgery.

The Smile Train uses these records for reviews of surgical quality, education, evaluation, and public relations purposes and will update you if any additional uses of the information become known. The personal health information contained in the medical records will be maintained in The Smile Train's worldwide web-based cleft lip and palate database (www.smiletrainexpress.org). Only authorized persons, such as physicians and other medical personnel, will have access to the records and the database.

The Smile Train will not share your health information with non-authorized outside third parties such as marketers or vendors. Additionally, The Smile Train will keep your health information private and confidential by implementing security standards that limit access to the database to only authorized personnel as determined by The Smile Train. The Smile Train also will allow you to view data contained in the medical record database and to remove your name and health information from the database upon request.

I understand the information written above. I give permission to send The Smile Train a completed Smile Train Medical Record Form for myself (*if of the age of majority in proper jurisdiction*)/my son/my daughter/other (*please circle one*).

I give The Smile Train permission to use this health information for quality assessment, education, evaluation and public relations purposes.

Signature of Patient/Parent/Guardian	Date	Signature of Witness	Date
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PART ONE: PATIENT INFORMATION

General Information

Patient Record Number		Did the parent/guardian sign the Guardian Consent form? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please proceed only if YES</i>	
Surname/Last Name	Middle Name	Given name/First Name	Date of Birth (<i>dd/mm/yyyy</i>) ____/____/____
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	Race <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian (white) <input type="checkbox"/> African (black) <input type="checkbox"/> Asian (Indian) <input type="checkbox"/> Mixed <input type="checkbox"/> Other		
Street Address		Town/Village/City	Province
Country	Zip/Postal code	Telephone	Is this patient sponsored by Smile Train? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Name of Partner/Organization		Name of Hospital	Country

Parent/Guardian Information

Surname/Last name	Middle initial	Given name/First name
Relationship with patient <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Grandparent <input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> Cousin <input type="checkbox"/> Friend <input type="checkbox"/> Other		
How did the patient hear about The Smile Train? <input type="checkbox"/> Charity Organization <input type="checkbox"/> Hospital/physicians <input type="checkbox"/> Newspaper and TV <input type="checkbox"/> Internet <input type="checkbox"/> Friends and relatives <input type="checkbox"/> Other		

Family History

Length of pregnancy: _____ months <input type="checkbox"/> Don't Know	Did the mother have complications during pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Were there any complications during birth? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	Did the mother smoke during pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Did the mother consume alcohol during pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	
Do any of the patient's parents and/or siblings brothers/sisters have a cleft lip, cleft palate, or cleft involving the face? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	
Do any other relatives (cousins, aunts, uncles, grandparents) have a cleft lip, cleft palate, or cleft involving the face? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	

Diagnosis

Patient Height _____ Patient Weight _____ Did the Patient have any lip or 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

Diagnosis (Description of Lip and Palate at birth or before any surgeries)

Lip	Patient's Left	Patient's Right
Type of Cleft Lip:		
1 - Not Cleft	<input type="checkbox"/>	<input type="checkbox"/>
2 - Complete	<input type="checkbox"/>	<input type="checkbox"/>
3 - Incomplete	<input type="checkbox"/>	<input type="checkbox"/>

Hard palate	Patient's Left	Patient's Right
Type of Cleft Palate:		
1 - Not Cleft	<input type="checkbox"/>	<input type="checkbox"/>
2 - Complete	<input type="checkbox"/>	<input type="checkbox"/>
3 - Incomplete	<input type="checkbox"/>	<input type="checkbox"/>
4 - Submucous	<input type="checkbox"/>	<input type="checkbox"/>

Alveolus	Patient's Left	Patient's Right
Type of Cleft Lip:		
1 - Not Cleft	<input type="checkbox"/>	<input type="checkbox"/>
2 - Complete	<input type="checkbox"/>	<input type="checkbox"/>
3 - Incomplete	<input type="checkbox"/>	<input type="checkbox"/>

Soft palate	Patient's Left	Patient's Right
Type of Cleft Palate:		
1 - Not Cleft	<input type="checkbox"/>	<input type="checkbox"/>
2 - Complete cleft	<input type="checkbox"/>	<input type="checkbox"/>
3 - Incomplete cleft	<input type="checkbox"/>	<input type="checkbox"/>
4 - Submucous	<input type="checkbox"/>	<input type="checkbox"/>

Are there additional craniofacial deformities? Yes No Don't Know

Does this patient have velopharyngeal insufficiency following prior cleft palate repair? Yes No Don't Know

Does this patient have abnormalities in any of the following areas? (check all that may apply)

Heart <input type="checkbox"/> Yes <input type="checkbox"/> No	Nose <input type="checkbox"/> Yes <input type="checkbox"/> No	Fingers or toes <input type="checkbox"/> Yes <input type="checkbox"/> No	Skull <input type="checkbox"/> Yes <input type="checkbox"/> No	Retarded Growth <input type="checkbox"/> Yes <input type="checkbox"/> No
Urinary system <input type="checkbox"/> Yes <input type="checkbox"/> No	Ears <input type="checkbox"/> Yes <input type="checkbox"/> No	Skin <input type="checkbox"/> Yes <input type="checkbox"/> No	Mandible <input type="checkbox"/> Yes <input type="checkbox"/> No	Mental Retardation <input type="checkbox"/> Yes <input type="checkbox"/> No
Eyes <input type="checkbox"/> Yes <input type="checkbox"/> No	Limbs (arms/legs) <input type="checkbox"/> Yes <input type="checkbox"/> No	Tongue <input type="checkbox"/> Yes <input type="checkbox"/> No	Speech <input type="checkbox"/> Yes <input type="checkbox"/> No	

Does the patient have allergies? Yes No Don't Know

Medication allergies

Other allergies

Other Health Problems

Name of Evaluator

Title of Evaluator

Clerk Surgeon Nurse Other

Date of Evaluation: (dd/mm/yyyy) _____ / _____ / _____

PART TWO: INTERVENTION INFORMATION

Surgical Treatment

Date of admission: (dd/mm/yyyy) _____ / _____ / _____ Date of the Surgical treatment: (dd/mm/yyyy) _____ / _____ / _____ Date of Discharge: (dd/mm/yyyy) _____ / _____ / _____

Name of the Surgeon

Name of the Anesthesiologist

Anesthesia Method General Local

Type of Operation (Check all surgical procedures that were conducted at the time of this hospitalization)

Primary Lip / Nose Unilateral Repair (partial or complete) Primary Lip / Nose Bilateral Repair (partial or complete) Primary Cleft Palate Repair

Fistula Repair Secondary Cleft Palate (Velopharyngeal) Repair Lip/Nose Revision Alveolar Bone Graft Other: _____

Type of Repairs Unilateral Lip Rotation-Advancement Variant Triangular Variant Others

Bilateral Lip Straight Line Forked Flap Others

Palate Langenbeck Variant Pushback Variant Others

Were there any complications, injury, or patient mortality? Yes No If no, please go directly to Additional Comments on Intervention below.

If yes, did these complications result in patient death or serious physical or psychological injury to the patient? Yes No If yes, please complete the Sentinel Event Report

If no, please indicate type of complication: Blood transfusion Breathing problems Dehiscence Delayed oral feeding Fistula Return to OR

Additional Comments On Intervention (Optional):

Photographic Records

Pre-operative Photo *(please check one)* Frontal Intra-oral

Date of Photo: ____ / ____ / ____ (dd/mm/yyyy)

Place photo here

Lip Repair (Frontal) / Palate Repair (Intra-oral)

Post-operative Photo *(please check one)* Frontal Intra-oral

Date of Photo: ____ / ____ / ____ (dd/mm/yyyy)

*Place photo here—wound should
be cleansed and free of blood*

Lip Repair (Frontal) / Palate Repair (Intra-oral)

Post-operative Photo (Frontal Smiling)

Date of Photo: ____ / ____ / ____ (dd/mm/yyyy)

*Place photo here—wound should
be cleansed and free of blood*

Frontal Smiling

(Optional) Please attach any other optional photos of this patient here

Please check all that apply pre worm's eye view post worm's eye view pre cleft side lateral post cleft side lateral

Date of Photos: ____ / ____ / ____ (dd/mm/yyyy)

Optional
