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: ☐ F ☐ M
Parent/Legal Guardian name:		
Address:		
City:	Province:	Postal code:
Home #:	Cell #:	Email:
Spoken languages: ☐ English ☐ Other:		Interpreter required: ☐ Y ☐ N
Client/family aware of the referral: ☐ Y ☐ N		

REFERRAL SOURCE		
Name:	Agency:	
Tel #:	Fax #:	Email:
Relationship to client:		

CLEFT INFORMATION			
Prenatal/Infant Referral:			**Suspected Submucosal Cleft Referral:**
☐ Prenatal Diagnosis	☐ Cleft Lip	☐ Cleft Palate	☐ Physical confirmation by ENT
Weeks Gestation	☐ Unilateral	☐ Bilateral	☐ Resonance confirmation by SLP
Other details:			
Other medical conditions:			

SOCIAL INFORMATION			
☐ No concerns	☐ Followed by social worker	☐ Financial/housing concerns	☐ Family stressors
☐ Emotional distress	☐ Child protection concerns	☐ Child in foster care	☐ 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