SmileTrain
Changing The World One Smile At A Time.

Patient Medical Record

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

PART ONE: PATIENT INFORMATION

General Information

Patient Record Number

Did the parent/guardian sign the Guardian Consent form? ☐ Yes ☐ No *Please proceed only if YES*

Surname/Last Name | **Middle Name** | **Given name/First Name** | **Date of Birth** *(dd/mm/yyyy)* ____ / ____ / ______

Gender ☐ Male ☐ Female ☐ Unknown **Race** ☐ Asian ☐ Caucasian (white) ☐ African (black) ☐ Asian (Indian) ☐ Mixed ☐ Other

Street Address | **Town/Village/City** | **Province**

Country | **Zip/Postal code** | **Telephone** | **Is this patient sponsored by Smile Train?** ☐ Yes ☐ No ☐ Unknown

Name of Partner/Organization | **Name of Hospital** | **Country**

Parent/Guardian Information

Surname/Last name | **Middle initial** | **Given name/First name**

Relationship with patient ☐ Mother ☐ Father ☐ Grandparent ☐ Brother ☐ Sister ☐ Aunt ☐ Uncle ☐ Cousin ☐ Friend ☐ Other

How did the patient hear about The Smile Train? ☐ Charity Organization ☐ Hospital/physicians ☐ Newspaper and TV ☐ Internet ☐ Friends and relatives ☐ Other

Family History

Length of pregnancy: ______ **months** ☐ Don't Know

Did the mother have complications during pregnancy? ☐ Yes ☐ No ☐ Don't Know

Were there any complications during birth? ☐ Yes ☐ No ☐ Don't Know

Did the mother smoke during pregnancy? ☐ Yes ☐ No ☐ Don't Know

Did the mother consume alcohol during pregnancy? ☐ Yes ☐ No ☐ 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? ☐ Yes ☐ No ☐ Don't Know

Do any other relatives (cousins, aunts, uncles, grandparents) have a cleft lip, cleft palate, or cleft involving the face? ☐ Yes ☐ No ☐ 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	☐	☐
	2 – Complete	☐	☐
	3 – Incomplete	☐	☐

Alveolus		**Patient's Left**	**Patient's Right**
Type of Cleft Lip:	1 – Not Cleft	☐	☐
	2 – Complete	☐	☐
	3 – Incomplete	☐	☐

Hard palate		**Patient's Left**	**Patient's Right**
Type of Cleft Palate:	1 – Not Cleft	☐	☐
	2 – Complete	☐	☐
	3 – Incomplete	☐	☐
	4 – Submucous	☐	☐

Soft palate		
Type of Cleft Palate:	1 – Not Cleft	☐
	2 – Complete cleft	☐
	3 – Incomplete cleft	☐
	4 – Submucous	☐

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

Does this patient have velopharyneal 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	☐ Yes	☐ No	**Nose**	☐ Yes	☐ No	**Fingers or toes**	☐ Yes	☐ No	**Skull**	☐ Yes	☐ No	**Retarded Growth**	☐ Yes ☐ No
Urinary system	☐ Yes	☐ No	**Ears**	☐ Yes	☐ No	**Skin**	☐ Yes	☐ No	**Mandible**	☐ Yes	☐ No		
Eyes	☐ Yes	☐ No	**Limbs** (arms/legs)	☐ Yes	☐ No	**Tongue**	☐ Yes	☐ No	**Speech**	☐ Yes	☐ No	**Mental Retardation**	☐ Yes ☐ 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: ______________________________

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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):*

PART THREE: RESULTS

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)*

Date of Event: *(dd/mm/yyyy)* _____ / _____ / _______ **Name of Hospital**

Optional