

Family and Physician Management Plan Summary for Children and Adolescents with Cleft Lip and Palate

This form will help you and your physician review current services and service needs. Please answer the questions about your current services on this page. Your physician will review your responses and complete the rest of the form.

Child's name _____ Today's date _____

Person completing the form _____

CURRENT SERVICES

1. Please list your/your child's current medications and any side effects.

2. What is your/your child's current school program?
School name _____ Grade _____
Teacher _____ Telephone _____
3. Do you/does your child receive any support services or other special programs at school (e.g., speech pathologist)? Please list.

4. Who is your/your child's surgeon? _____
Date last seen _____
5. Who are your/your child's other medical and dental service providers?
Dentist _____
Orthodontist _____
Plastic surgeon _____
Otolaryngologist _____
Speech-language pathologist _____
Audiologist _____ Date hearing was last tested _____
Any hearing concerns?

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6. Who are your/your child's other community service providers?
Community health nurse _____
Other _____
7. Do you also receive services from a cleft lip and palate team of specialists?
Contact person _____
Location _____
8. Have you/has your child had any blood tests, radiologic (X-ray) examinations, or other procedures since your last visit? If yes, please describe.
9. Have you/has your child been hospitalized or received surgery since your last visit? If yes, describe.
10. Please note your/your child's accomplishments since your last visit. Consider activities at home, in your neighborhood, or at school, as well as success with treatments.
11. What goals (i.e., skills) would you/your child like to accomplish in the next year? Consider activities at home, in your neighborhood, or at school, as well as success with a treatment.
12. What questions or concerns would you like addressed today?

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The Family and Physician Management Plan Summary should be completed at each annual review and more often as needed. It is intended to be used with the Guidelines for Care, which provide a more complete listing of clinical issues at different ages as well as recommended evaluations and treatments.

Child's name _____ Person completing form _____ Today's date _____

Clinical issues	Currently a problem?	Evaluations needed	Treatment recommendations	Referrals made	Date for status check
Family's Questions					
Cause of the Cleft Lip and/or Palate (CLP)					
Growth/Nutrition Feeding problems					
Surgical Checklist Initial lip repair Initial palate repair Lip or nasal revisions Myringotomy/tube placement Alveolar bone grafting Cleft septorhinoplasty Surgical improvement of velopharyngeal closure if indicated Orthognathic surgery Other					
Dental and Orthodontic Care					

Family and Physician Management Plan Summary for Children and Adolescents with Cleft Lip and Palate (continued)

Child's name _____ Person completing form _____ Today's date _____

Clinical issues	Currently a problem?	Evaluations needed	Treatment recommendations	Referrals made	Date for status check
Hearing Status/Middle-Ear Function					
Risk for Airway Obstruction					
Associated Medical Problems Visual problems or strabismus Seizures Craniosynostosis Other congenital defects					
Speech-Language Progress Need for speech-language therapy Poor speech intelligibility Voice quality (nasality)					
Developmental/School Progress Current school achievement Review individualized family services plan (IFSP) or individualized education program (IEP) with family					

Family and Physician Management Plan Summary for Children and Adolescents with Cleft Lip and Palate (continued)

Child's name _____ Person completing form _____ Today's date _____

Clinical issues	Currently a problem?	Evaluations needed	Treatment recommendations	Referrals made	Date for status check
Social Skills Involvement in peer-group activities at school and in the community					
Self-Care/Independence					
Family Support Services					
Anticipatory Guidance List issues discussed and materials provided					
Collaboration with Community Agencies School Community health nurse					

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Child's name _____ Person completing form _____ Today's date _____

Clinical issues	Currently a problem?	Evaluations needed	Treatment recommendations	Referrals made	Date for status check
Comments					

Next update of the Management Plan Summary _____

Signature _____ Date _____
(Child and parent)

Signature _____ Date _____
(Health professional)