REFERRAL FOR SERVICE
Cleft Lip and / or Palate Team Referral
(Birth to age 19)

Client Name ______________________

DOB *(dd / mm / yyyy)* ______________________

File # ______________________

PHN ______________________

Date of Referral *(dd / mm / yyyy)*	Do you identify yourself as an Aboriginal person? ☐ Yes ☐ No
Referral Source: *(Please include contact Information / relationship to client)*	

	Name of Parent(s) / Legal Guardian / Foster Parent(s)	Relationship to Client	Most convenient phone	Legal Guardian?
1				☐ Yes ☐ No
2				☐ Yes ☐ No
3				☐ Yes ☐ No

Client's address		
City	Postal Code	Email
Mailing address *(if different)*		
	City	Postal Code
Language spoken at home	Interpreter needed? ☐ Yes ☐ No	

Description of Cleft (select all that apply):

- ☐ cleft lip and palate
- ☐ isolated cleft lip
- ☐ isolated cleft of soft palate
- ☐ isolated cleft of hard palate
- ☐ cleft as part of other anomalies / syndrome
- ☐ unilateral left
- ☐ unilateral right
- ☐ bilateral

Other information

- ☐ Kelowna Plastic Surgeon has been consulted
- ☐ Newborn Hearing Screening complete
- ☐ cleft palate bottle is in use

Comments / attach pertinent reports:

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Parent questions or current concerns

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Family Physician

Name of Current Service Providers	Professional Designation

Permanent part of the health record

Submit electronically by using the button below or send this request for service to:

Kelowna Community Health and Services Centre
505 Doyle Avenue Tel: (250) 469-7070 Ext. 12074
Kelowna, V1Y 0C5 Fax: (250) 868-7809

Date	Name of Person Referring/Signature of Person Referring