NATIONAL NEONATAL REGISTRY (CRF 08)

Supplementary Data on Neural Tube Defects and Cleft Lip and Palate

1. Centre Name:			Office use: /
2. Name:		**3. RN:**	
4. Mother's I/C Number:	**New IC:**		Centre:
	Passport:		
5. Case definition:	☐ **LiveBirth (To submit with full CRF 08 fill all Sections)** ☐ **StillBirth (To submit with CRF 08 and fill only Section 1 and 2 from Question 1-18)**		

A. NEURAL TUBE DEFECTS		☐ Anencephaly ☐ Spina bifida ☐ Encephalocele ☐ Others : .....
B. CLEFT LIP AND PALATE (CLP)	**a. Cleft Lip an Palate (CLP)**	☐ Isolated (CLP) ☐ Syndromic CLP
	b. Location	☐ Cleft lip only ☐ Cleft lip and palate ☐ Cleft palate only ☐ Others
	c. Laterality	☐ Left side only ☐ Bilateral ☐ Right side only ☐ Median

1. Gravida :		**Para :** ☐☐ **Abortion :** ☐☐
2. Family history of congenital malformation (CM):	**a) Parents:**	☐ Yes ☐ No ☐ Unknown
	b) Siblings:	☐ Yes ☐ No ☐ Unknown
	c) Relatives	☐ Yes ☐ No ☐ Unknown
	If "yes", please specify type CM	
3. Folic acid supplements:		☐ Yes, before conception ☐ No folate at all ☐ Yes, from the first trimester ☐ Don't know ☐ Yes, from the 2nd / 3rd trimester
4. Maternal diabetes:		☐ No ☐ Pre-existing insulin dependent diabetes mellitus ☐ Pre-existing non-insulin dependent diabetes mellitus ☐ Gestational diabetes (on insulin) ☐ Gestational diabetes (on diet restriction) ☐ Don't know
5. The first ultrasound scan was done during:		☐ First trimester ☐ Third trimester ☐ Second trimester ☐ None
6. Total number of ultrasound scans done during this pregnancy :		☐☐
7. Was the congenital malformation detected by the ultrasound scans?		☐ Yes ☐ No ☐ Don't know
8. Maternal serum screening test done?		☐ Yes ☐ No ☐ Don't know