Section / Data item	Field name	Response values / labels	Description These descriptions are available through information (I) buttons found next to each data	Guidance & Notes	¥
Section / Data item	rieid name	Response values / labels	frese descriptions are available prough mormation (i) buttons round next, to each data- item.	Guidance & Notes	
atient Registration					Yes
atient Consent					Yes
Consent status*	consent**	1 = No 2 = Yes 3 = Unknown, awaiting verification 4 = Not possible to verify	As indicated on consent form.	* Notification fields I.e. Should always be completed - even if patient consent = No (1) / DK (3) / Not verified (4)	Yes - Item #1 of 16
Consent status: Please give further details	consent_details	Text	Reason why if choose 3 or 4 for 'consent'. "*Please give further details:" (Field name: consent details).		No
Linkage of CRANE data to Health data*	consent_health	1 = No 2 = Yes 3 = Unknown, awaiting verification 4 = Not possible to verify 5 = Registered prior to new 2016 system (only visible to Admin)	As indicated on consent form. This field may also capture future requests to NOT link patient's CRANE data to Health data.	* Notification fields i.e. Should always be completed - even if patient consent = No (1) / DK (3) / Not verified (4)	Yes - Item #2 of 16
inkage of CRANE data to Education data*	consent_education	1 = No 2 = Yes 3 = Unknown, awaiting verification 4 = Not possible to verify 5 = Registered prior to new 2016 system (only visible to Admin)	As indicated on consent form. This field may also capture future requests to NOT link patient's CRANE data to Education data.	* Notification fields I.e. Should always be completed - even if patient consent = No (1) / DK (3) / Not verified (4)	Yes - Item #3 of 16
Cleft team details					
Administrative unit name*	unit_id**	Administrative unit name (shown in text format).	Administrative unit name. More than one unit name may be available for selection from a drop-down menu; based on unit/region permissions. [This takes a 4-digit numeric value in data exports. E.g. 9011 = Royal Victoria Infirmary (Newcastle)]	* Notification fields i.e. Should always be completed - even if patient consent = No (1) / DK (3) / Not verified (4)	No
Administrative unit number*	unit_no**	Number or alpha-numeric value (e.g. AB12345).	Preferences ("hub") hospital. This may be a number or an alpha-numeric value (e.g. AB12345).	* Notification fields I.e. Should always be completed - even if patient consent = No (1) / DK (3) / Not verified (4)	No
Hospital name	hospital_id	Hospital name (shown in text format).	Hospital name. Local ("spoke") hospitals will be available for selection from a drop-down menu. Your local ("spoke") hospital may be the same as your administrative unit. [This takes a 6-digit numeric value in data exports. E.g. 901100 = Royal Victoria Infirmary (Newcostle) and 901101 = Sunderland Royal Hospital.]		No
Hospital number	hospital_no	Number or alpha-numeric value (e.g. A123456).	Patient number used in local hospital. This may be a number or an alpha-numeric value (e.g. A123456).		No
Current patient	current**	1 = Attending centre 2 = Not attending centre	Indicates if the patient is no longer currently attending the centre		No
Reason not current	not_current_reason	Text	Reason patient is not currently attending e.g. emigrated		No
Patient details					Yes
CRANE ID*	crane_id**	Number	Unique patient identifier automatically generated when a new patient is added.	 Notification fields I.e. Should always be completed - even if patient consent = No (1) / DK (3) / Not verified (4) 	No
ratient's NHS Number*	nhs**	Either: *Valid NHS Number = Valid 10 digit number. *Valid non NHS number (unavailable/unapplicable) = 10 zeros. *Blank/null	NHS Number	* Notification fields I.e. Should always be completed - even if patient consent = No (1) / DK (3) / Not verified (4)	Yes - Item #4 of 16
eason patient's NHS Number not available*	nhs_na	1=Patient from the Channel Islands 2=Patient from Scotland 3=Private UK patient 4=Non-UK resident 5=Other	Where NHS Number is not available, please provide a reason.	* Notification fields i.e. Should always be completed - even if patient consent = No (1) / DK (3) / Not verified (4)	No
Reason patient's NHS Number not available - other reason*	nhs_na_oth	Text			No
Date of birth*	dob**	DD / MM / YYYY		* Notification fields I.e. Should always be completed - even if patient consent = No (1) / DK (3) / Not verified (4)	Yes - Item #5 of 16

KEY: *'Notification only' data items / fields I.e. Patient consent = No/DK. ** 'Patient registration short' Export fields. ¥ Data items / fields that constitute the minimum CRANE dataset.

			Description		
Section / Data item	Field name	Response values / labels		Guidance & Notes	Minimum Dataset*
Date deceased*	dod**	DD / MM / YYYY	Only complete where applicable.	* Notification fields I.e. Should always be completed - even if patient consent = No (1) / DK (3) / Not verified (4)	No
Present surname	surname**	Text			No
First names	forenames**	Text	Forenames		No
Sex*	sex	1 = Female 2 = Male	Patient gender	* Notification fields I.e. Should always be completed - even if patient consent = No (1) / DK (3) / Not verified (4)	Yes - Item #6 of 16
Postcode	pcode	8-character, alpha-numeric field	Postcode of current residence		No
Postcode History	pcode_history	Previous postcodes in 8-character, alpha-numeric format Plus associated date at which each previous postcode was originally set.	t.		No
Surname at birth (if different)	surname_birth	Text			No
First contact information					
Hospital of birth/referral*	hosp_refer	Text	Hospital of birth or referral if home birth	* Notification fields I.e. Should always be completed - even if patient consent = No (1) / DK (3) / Not verified (4)	Yes - Item #7 of 16
Timing of diagnosis*	diag_time	1 = Antenatal 2 = At birth (within 24 hours of birth) 22 = Within 72 hours 3 = Within 1 week 4 = Within 1 month 5 = Within 6 months 6 = Later than 6 months	Time when cleft diagnosis was made for the first time	* Notification fields I.e. Should always be completed - even if patient consent = No (1) / DK (3) / Not verified (4)	Yes - Item #8 of 16
For antenatal, date and time cleft team informed of antenatal diagnosis*	an_team_inf	DD/MM/YYYY HH:MM	Date and time when cleft team was informed of antenatal cleft diagnosis	* Notification fields I.e. Should always be completed - even if patient consent = No (1) / DK (3) / Not verified (4)	No
For antenatal, date and time of first contact with cleft team following antenatal diagnosis*	an_team_con	DD/MM/YYYY HH:MM	Date and time when cleft team made first contact with baby's family following antenatal diagnosis (contact does not imply a face-to-face visit, it can be by letter, text, phone, Skype).	* Notification fields I.e. Should always be completed - even if patient consent = No (1) / DK (3) / Not verified (4)	No
Was contact made within 24 hours of receiving the antenatal referral by a Clinical Nurse Specialist?*	an_cns_con	1 = No 2 = Yes	Whether or not contact was made within 24 hours of receiving the antenatal referral by a Clinical Nurse Specialist (contact does not imply a face-to-face visit, it can be by letter, text, phone, Skype).	* Notification fields i.e. Should always be completed - even if patient consent = No (1) / DK (3) / Not verified (4)	No
Reason contact NOT made within 24 hours of receiving the antenatal referral?*	an_cns_reason	1 = No answer to phone calls. 2 = Incorrect contact details. 3 = Interpreter required (and not possible to arrange within 24 hours). 9 = Other reason.			No
Other reason contact NOT made within 24 hours of receiving the antenatal referral details*	an_cns_spec	Text	Details of other reason for not making contact within 24 hours of receiving the antenatal referral		No
For all births					Yes
For all births, date and time cleft team informed following birth*	team_inf	DD/MM/YYYY HH:MM	Date and time when cleft team was informed of cleft diagnosis following birth	* Notification fields i.e. Should always be completed - even if patient consent = No (1) / DK (3) / Not verified (4)	Yes - Item #9 of 16
Date and time of first contact with cleft team following birth*	team_con	DD / MM / YYYY HH:MM	Date and time when cleft team made first contact with baby's family following birth (contact does not imply a face-to-face visit, it can be by letter, text, phone, Skype).	* Notification fields I.e. Should always be completed - even if patient consent = No (1) / DK (3) / Not verified (4)	Yes - Item #10 of 16
Date and time of first visit by a member of the cleft team following birth*	team_vis	DD / MM / YYYY HH:MM	Date and time when a member of the cleft team first visited baby's family following birth	* Notification fields i.e. Should always be completed - even if patient consent = No (1) / DK (3) / Not verified (4)	Yes - Item #11 of 16
Was a visit made within 24 hours of receiving the postnatal referral by a Clinical Nurse Specialist?*	cns_con	1 = No 2 = Yes	Whether or not visit was made within 24 hours of receiving the postnatal referral by a Clinica Nurse Specialist	Notification fields I.e. Should always be completed - even if patient consent = No (1) / DK (3) / Not verified (4)	Yes - Item #12 of 16
Reason visit NOT made within 24 hours of receiving the postnatal referral?*	cns_con_reason	1 = No CNS available. 2 = Travel distance from unit (not possible to complete journey within 24 hours). 3 = Clinical decision - feeding well and no concerns. 4 = Clinical decision - other comorbidities, advised by NICU not to attend. 9 = Other reason.			No
Other reason visit NOT made within 24 hours of receiving the postnatal referral details*	cns_con_spec	Text	Details of other reason for not visiting within 24 hours of receiving the postnatal referral		No

			KEY: * 'Notification only' data items / fields I.e. Patient consent = No/DK. ** 'Patient reg	istration short' Export fields. $ m f Y$ Data items / fields that constitute	the minimum CRANE dataset.
Section / Data item	Field name	Response values / labels	Pescription These descriptions are wall table through information () buttons found next to each data (ten	Guidance & Notes	Minimum Dataset
Cleft Details*			This form is used to describe the cleft. It is required for each new patient.	* Notification fields I.e. Should always be completed - even if patient consent = No (1) / DK (3) / Not verified (4)	No
Is this a submucous cleft*	submucous	1 = No 2 = Yes	Presence of submucous cleft palate (SMCP). Recording of a submucous cleft palate should automatically reduce cleft description options below. Only an 'incomplete' soft palate should be available when completing the LAHSAL items below. If applicable, users should record the presence of a submucous cleft palate by: 1. Responding 'yes' to this question ("Is this a submucous cleft?"). 2. Then users should record LAHSAL code to allow a cleft type category of CP, UCLP or BCLP to be assigned to this patient / derived by the Items below.	* Notification fields I.e. Should always be completed - even if patient consent = No (1) / DK (3) / Not verified (4)	Yes - Item #13 of 16
Pierre Robin Sequence present*	pierrerobin	1 = No 2 = Yes	Birth defect where micrognathia and glossoptosis appear together with cleft palate. Recording of a PR sequence being present will automatically reduce cleft description options below. Only hard palate and soft palate will be available for completion		Yes - Item #14 of 16
Forme Fruste present*	formefruste	1 = No 2 = Yes	Presence of a "Forme Fruste" or microform cleft lip, exhibited as a depression or indentation in the lip and slight alteration of the nostril floor or alar shape. Users should record a LAHSAL code indicating an incomplete cleft of the lip on the affected side. These patients will be assigned to the CL cleft type group for the purposes of analysis.		Yes - Item #15 of 16
Cleft description					Yes
Simonart's Bands - Patient's right*	cd1_band_right	0 = Not present/No (.) 2 = Yes (Y)	Cleft description element 1 - Presence of Simonart's Bands on right hand side	* Notification fields I.e. Should always be completed - even if patient consent = No (1) / DK (3) / Not verified (4)	Yes - Item #16a of 16 (to calculate I_code)
Lip - Patient's right*	cd2_lip_right	0 = Not present (.) 1 = Incomplete (I) 2 = Complete (C)	Cleft description element 2 - Presence of cleft lip on right hand side	• Notification fields I.e. Should always be completed - even if patient consent = No (1) / DK (3) / Not verified (4)	Yes - Item #16b of 16 (to calculate I_code)
Alveolus - Patient's right*	cd3_alv_right	0 = Not present (.) 1 = Incomplete (I) 2 = Complete (C)	Cleft description element 3 - Presence of cleft alveolus on right hand side	* Notification fields I.e. Should always be completed - even if patient consent = No (1) / DK (3) / Not verified (4)	Yes - Item #16c of 16 (to calculate I_code)
Hard Palate*	cd4_hard	0 = Not present (.) 1 = Incomplete (I) 2 = Complete (C)	Cleft description element 4 - Presence of cleft hard palate	* Notification fields I.e. Should always be completed - even if patient consent = No (1) / DK (3) / Not verified (4)	Yes - Item #16d of 16 (to calculate I_code)
Soft Palate*	cd5_soft	0 = Not present (.) 1 = Incomplete (I) 2 = Complete (C)	Cleft description element 5 - Presence of cleft soft palate	* Notification fields i.e. Should always be completed - even if patient consent = No (1) / DK (3) / Not verified (4)	Yes - Item #16e of 16 (to calculate I_code)
Alveolus - Patient's left*	cd6_alv_left	0 = Not present (.) 1 = Incomplete (I) 2 = Complete (C)	Cleft description element 6 - Presence of cleft alveolus on left hand side left hand side	* Notification fields I.e. Should always be completed - even if patient consent = No (1) / DK (3) / Not verified (4)	Yes - Item #16f of 16 (to calculate I_code)
Lip - Patient's left*	cd7_lip_left	0 = Not present (.) 1 = Incomplete (I) 2 = Complete (C)	Cleft description element 7 - Presence of cleft lip on left hand side	* Notification fields I.e. Should always be completed - even if patient consent = No (1) / DK (3) / Not verified (4)	Yes - Item #16g of 16 (to calculate I_code)
Simonart's Bands - Patient's left*	cd8_band_left	0 = Not present/No (.) 2 = Yes (Y)	Cleft description element 8 - Presence of Simonart's Bands on left hand side	* Notification fields I.e. Should always be completed - even if patient consent = No (1) / DK (3) / Not verified (4)	Yes - Item #16h of 16 (to calculate I_code)
LAHSAL code*	I_code	Text 6-characters	Cleft description displayed in LAHSAL code format automatically generated from elements (2-7) of cleft description		Yes - Item #16 of 16
Cleft type category (derived from LAHSAL code)*	cleft_type	1 = Isolated cleft lip (CL) 2 = Isolated cleft palate (CP) 3 = Unilateral cleft lip and palate (UCLP) 4 = Bilateral cleft lip and palate (BCLP)	Cleft type category automatically generated from elements (2-7) of cleft description	* Notification fields I.e. Should always be completed - even if patient consent = No (1) / DK (3) / Not verified (4)	Yes - Calculated by CRANE from I_code (above)
Cleft type category in the absence of LAHSAL code (CRANE office use only)*	cleft_type_without_lahsal	1 = Isolated cleft lip (CL) 2 = Isolated cleft palate (CP) 3 = Unilateral cleft lip and palate (UCLP) 4 = Bilateral cleft lip and palate (BCLP)	Cleft category in absence of completed LAHSAL code manually assigned by CRANE Database Administrator at centre's request		No

			KEY: * 'Notification only' data items / fields I.e. Patient consent = No/DK. ** 'Patient reg	istration short' Export fields. ¥ Data items / fields that constitute the	minimum CRANE datas
Section / Data item	Field name	Response values / labels	Description These descriptions are available through information (f) buttons found next to each date.	Guidance & Notes	Minimum Dataset
Section / Data tem		nesponse values, napels	item.		Minimum Dataset
Record created date	date_created	DD / MM / YYYY HH:MM	The date/time that the record for this crane_id was first added to the database (applies from 27/09/2001) - automatically generated.		No
Notes					
Notes	notes		Additional notes for this patient. This is for units' / hospitals' own use.		No
Surgical procedures					No
To be specified in soon					No
Syndromes					No
Confirmed syndromic diagnosis present	syndrome	1 = No 2 = Yes, named 3 = Yes, unknown	Does the child have a confirmed syndromic diagnosis? The confirmed diagnosis can be either a named syndrome or an unknown syndrome		No
Syndrome name(s)	syndrome_name1	Text	For named syndrome: Specify up to two named syndromes		No
	syndrome_name2	Text			No
Description of affected systems	syndrome_unk_desc	Text	For unknown syndrome: Describe the body systems affected by the syndrome		No
Outcome information is collected according to age of patients and cleft type: All Outcomes			For all types of outcomes and age ranges we capture reasons why the record is excluded or is not available for that patient.		No
Reasons Outcomes not collected					No
Reason outcome not collected	outcome_notcoll_reason (_g0, _g1, _g5, _o5, _d5, _p5, _s5, s_10, d_10)	1= Patient deceased or emigrated 2= Patient transferred in or out of area 3= Syndromic Diagnosis 4= Clinically contraindicated (other than syndromic) - this record type for this patient 5= Lack of staff / facilities / equipment 6= Patient DNA / cancelled / did not consent / cooperate 9= Other reason	Reason outcome not collected		No
Clinically contraindicated (other than syndromic) reason - details	clincon_nonsyndr_specify (_g0, _g1, _g5, _o5, _d5, _p5, _s5, s_10, d_10)	Text	Details of clinically contraindicated (other than syndromic) reason outcome not collected		No
Other reason - details	outcome_notcoll_specify (_g0, _g1, _g5, _o5, _d5, _p5, _s5, s_10, d_10)	Text	Details of other reason outcome not collected		No
Outcomes				A field to identify the age timepoint is automatically generated by the system and specifies outcome(s) relevant for data collection (i.e. At birth, at 1 year, 5 years, 10 years, etc).	No
Outcome at Birth					No
Child Growth					No
Gestational age	gest_age	Integer	Baby's gestational age at birth (weeks)		No
Weight at birth	weight_g0	Number (up to 2 decimal places)	Body weight at birth (kg). (NOT to be adjusted for gestational age)		No
Date weight at birth record taken	Weight_g0_date	DD / MM / YYYY			No
Outcome at 1 year					No
Child Growth					No
Weight at 1 year	weight_g1	Number (up to 2 decimal places)	Body weight at 1 year (kg)		No
Date weight at 1 year record taken	Weight_g1_date	DD / MM / YYYY			No
Height at 1 year	height_g1	Number (up to 1 decimal place)	Height at 1 year (cm)		No
Date height at 1 year record taken	height_g1_date	DD / MM / YYYY			No
Outcome at 5 years					No
Child Growth					No
Weight at 5 years	weight_g5	Number (up to 2 decimal places)	Body weight at 5 years (kg)		No
Date weight at 5 years record taken	Weight_g5_date	DD / MM / YYYY			No
Height at 5 years	height_g5	Number (up to 1 decimal place)	Height at 5 years (cm)		No
Date height at 5 years record taken	height_g5_date	DD / MM / YYYY			No
Orthodontics			Complete UCLP cases only (i.e. 'LAHS' or 'HSAL')		No
Date study model taken	study_model_o5	DD / MM / YYYY			No
Date photos taken	photos_taken_o5	DD / MM / YYYY			No

			KEY: * 'Notification only' data items / fields I.e. Patient consent = No/DK. ** 'Patient reg	gistration short' Export fields. $ m f Y$ Data items / fields that constitute the	minimum CRANE dataset.
Section / Data item	Field name	Response values / labels	Description These descriptions are excluded through intermedian (i) butters found used to each data. Here	Guidance & Notes	Minimum Dataset
Five Year Old Index (internal)	five_year_internal_o5	Score 1-5	Five Year Old Index internally validated score	Externally validated score preferred, provide internal score only if external score not available	No
Five Year Old Index (external)	five_year_external_o5	Score 1-5	Five Year Old Index externally validated score		No
Paediatric dentistry					No
Date record taken Total number of decayed, missing or filled teeth in	record_taken_d5	DD / MM / YYYY	Total number of decayed, missing or filled teeth (dmft) in the primary dentition at age 5 years		No
primary dentition (dmft)	dmft_d5	Integer	(If none, specify 0)	S	No
Total number of decayed teeth in primary dentition (dt)	dt_d5	Integer	Total number of decayed teeth (dt) in the primary dentition at age 5 years (If none, specify 0)		No
Total number of missing teeth in primary dentition (mt)	mt_d5	Integer	Total number of missing teeth (mt) in the primary dentition at age 5 years(If none, specify 0)		No
Total number of filled teeth in primary dentition (ft)	ft_d5	Integer	Total number of filled teeth (ft) in the primary dentition at age 5 years (If none, specify 0)		No
Care Index	care_index_d5	Number between 0 and 1 (up to 3 decimal places)	Care Index (ft/dmft) automatically generated	Calculation of a value for this field requires the ft and dmft fields to be specified	No
Treatment Index	treat_index_d5	Number between 0 and 1 (up to 3 decimal places)	Treatment Index ((mt+ft)/dmft) automatically generated	Calculation of a value for this field requires the mt, ft and dmft fields to be specified	No
Psychology					No
Date of 1st face to face psychosocial screen	date_scr1_p5	DD / MM / YYYY			No
Date of psychosocial screen at age 5	date_scr_p5	DD / MM / YYYY			No
TIM score	tim_total_p5	2= 0b 3= 0c 4= 0d 5= 0e 6= 1a 7= 1b 8= 2a 9= 2b 10= 2c 11= 3 12= 4 13= 5 14= 6	Tiers of Involvement Measure (TIM) scores take the form of 0a, 0b, 0c, 0d, 0e, 1a, 1b, 2a, 2b, 2c, 3, 4, 5 or 6.		No
Parent SDQ Total	sdq_total_p5	Integer / Number between 0 and 40	Total number score for parent Strengths & Difficulties Questionnaire (ranging between 0-40).		No
Parent SDQ Emotional	sdq_emotion_p5	Integer / Number between 0 and 10	Number score for parent Strengths & Difficulties Questionnaire - Emotional score (ranging between 0-10).		No
Parent SDQ Conduct	sdq_conduct_p5	Integer / Number between 0 and 10	Number score for parent Strengths & Difficulties Questionnaire - Conduct score (ranging between 0-10).		No
Parent SDQ Hyperactivity [0-10]	sdq_hyper_p5	Integer / Number between 0 and 10	Number score for parent Strengths & Difficulties Questionnaire - Hyperactivity score (ranging between 0-10).		No
Parent SDQ Peer Problems	sdq_peer_p5	Integer / Number between 0 and 10	Number score for parent Strengths & Difficulties Questionnaire - Peer Problems score (ranging between 0-10).		No
Parent SDQ Prosocial	sdq_prosocial_p5	Integer / Number between 0 and 10	Number score for parent Strengths & Difficulties Questionnaire - Prosocial score (ranging between 0-10).		No
Outcome at 5 and 10 years					No
Speech and Language Therapy: CAPS-A			CP / UCLP / BCLP cases only		No
Date of Speech Assessment Recording	speech_assess_date_s5 (and _10)	DD / MM / YYYY			No
VP surgery / Fistula repair before assessment	vp_fist_s5 (and _10)	1 = No 2 = Yes			No
Context of evaluation	context_eval_s5 (and _10)	1 = Consensus listened (includes an external CAPS-A trained listener) 2 = Consensus listened (internal listeners with a minimum of 2 CAPS-A trained listeners) 3 = Other			No

			KEY: * 'Notification only' data items / fields i.e. Patient consent = No/DK. ** 'Patient re	gistration short' Export fields. ¥ Data items / fields that constitute the	minimum CRANE dataset
Section / Data item	Field name	Response values / labels	Description These descriptions are qualified through information (i) bustons found next to each date them.	Guidance & Notes	Minimum Dataset
Hypernasality	hyper_s5 (and _10)	0 1 2 3 4 8			No
Hyponasality	hypo_s5 (and _10)	0 1 2 8			No
Audible Nasal Emission	audible_s5 (and _10)	0 1 2 8			No
Nasal Turbulence	nasal_s5 (and _10)	0 1 2 8			No
Anterior Cleft Speech Characteristics (CSCs)					No
Dentalisation / interdentalisation	ant_dent_s5 (and _10)	0 = A 2 = B		Definitions: A Dark Green on CAPS-A B Light Green on CAPS-A C Amber on CAPS-A D Red on CAPS-A	No
Lateralisation / lateral	ant_lat_s5 (and _10)	0 = A 1 = B 2 = C		As above	No
Palatalisation / Palatal	ant_pal_s5 (and _10)	0 = A 1 = B 2 = C		As above	No
Posterior CSCs					No
Double articulation (posterior)	post_double_s5 (and _10)	0 = A 1 = B 2 = C		As above	No
Backed to velar / uvular	post_velar_s5 (and _10)	0 = A 1 = C 2 = D		As above	No
Non Oral CSCs					No
Pharyngeal articulation	non_oral_phar_s5 (and _10)	0 = A 1 = C 2 = D		As above	No
Glottal Articulation	non_oral_glot_s5 (and _10)	0 = A 1 = C 2 = D		As above	No
Active Nasal Fricatives	non_oral_fric_s5 (and _10)	0 = A 1 = C 2 = D		As above	No
Double articulation (non-oral)	non_oral_artic_s5 (and _10)	0 = A 1 = C 2 = D		As above	No
Passive CSCs					No
Weak and or nasalised consonants	pass_weak_s5 (and _10)	0 = A 1 = C 2 = D		As above	No
Nasal realisation of plosives	pass_nasal_s5 (and _10)	0 = A 1 = C 2 = D		As above	No
Gliding of fricatives	pass_glide_s5 (and _10)	0 = A 1 = C 2 = D		As above	No
Outcome at 10 years					No
Paediatric dentistry					
Date record taken	record_taken_d10	DD / MM / YYYY			No
Total number of decayed, missing or filled teeth in primary dentition (DMFT)	dmft_d10	Integer	Total number of decayed, missing or filled teeth (dmft) in the primary dentition at age 5 year (If none, specify 0)	S	No
Total number of decayed teeth in primary dentition (DT)	dt_d10	Integer	Total number of decayed teeth (dt) in the primary dentition at age 5 years (If none, specify 0))	No
Total number of missing teeth in primary dentition (MT)	mt_d10	Integer	Total number of missing teeth (mt) in the primary dentition at age 5 years(If none, specify 0)		No
Total number of filled teeth in primary dentition (FT)	ft_d10	Integer	Total number of filled teeth (ft) in the primary dentition at age 5 years (If none, specify 0)	Colculation of a value for this field and the first the	No
Care Index	care_index_d10	Number between 0 and 1 (up to 3 decimal places)	Care Index (ft/dmft) automatically generated	Calculation of a value for this field requires the ft and dmft fields to be specified	No
Treatment Index	treat_index_d10	Number between 0 and 1 (up to 3 decimal places)	Treatment Index ((mt+ft)/dmft) automatically generated	Calculation of a value for this field requires the mt, ft and dmft fields to be specified	No