

*Place Patient Information  
Label Here*

Telephone: \_\_\_\_\_

Height: \_\_\_\_\_                      Weight: \_\_\_\_\_

**To:** Melbourne Children's Sleep Unit  
\_\_\_\_\_

**Date:** \_\_\_\_\_

**Referring Dr:** \_\_\_\_\_

**Provider number:** \_\_\_\_\_

**Ref Dr Signature:** \_\_\_\_\_

**Send Correspondence To:**  
\_\_\_\_\_  
\_\_\_\_\_

<b><u>Indications for Study:</u></b>	<b><u>Specific Tests / Requirements:</u></b>	<b><u>Special Needs:</u></b>
<input type="checkbox"/> OSAS <input type="checkbox"/> Hypoventilation <input type="checkbox"/> Periodic Leg Movement <input type="checkbox"/> EDS <input type="checkbox"/> Epilepsy <input type="checkbox"/> Parasomnias <input type="checkbox"/> Narcolepsy <input type="checkbox"/> Behavioural	<input type="checkbox"/> MSLT <input type="checkbox"/> nCPAP (Titration / Follow-Up) <i>Max pressure before contacting</i> <i>On-call physician: _____</i> <input type="checkbox"/> BiLevel (Titration / Follow-Up) ** <input type="checkbox"/> Ventilator ** <input type="checkbox"/> Suppl O2: ** _____ L/min <i>** Additional form to be completed</i>	<input type="checkbox"/> Tracheostomy <input type="checkbox"/> Suctioning <input type="checkbox"/> Gastrostomy / Night Feeds <input type="checkbox"/> Feeding Pump <input type="checkbox"/> Wheelchair bound <input type="checkbox"/> Other : _____

**Co-existing conditions:**       Asthma       Chronic Lung Disease       Neuromuscular Disease

Scoliosis       Developmental Delay       Syndrome: \_\_\_\_\_       Other: \_\_\_\_\_

**Clinical Notes:** \_\_\_\_\_

**Medications:** \_\_\_\_\_

**Is this child co-operative:**       Yes       No

**Special requirements for the study:** \_\_\_\_\_

\_\_\_\_\_

**For Infants (ie. <12 months):**      **Apnoea monitor in use:**  Yes       No

**Body Position:**       alternating (supine & prone)       All Supine       All Prone       Spontaneous positions

Cancellation List (parents willing to come at short notice)

***Please fax this form Attention: Fiona McArdle on 9594 6224***