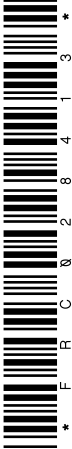

The **Royal Children's Hospital** Melbourne

# Overnight Oximetry Request Form

**Department of Respiratory Medicine**
**RCH**

## Please fax to RCH @ Home: 9345 6231

**Name:** ……………….…………………………….. **RCH UR:** ………………. **DOB:** ……………….

**Address:** ………………………….……………………………………………………………..

**Phone:** …………………………

**Requesting Doctor:** ______________________________ **Clinic Name:** ______________

**Doctor's email address for report:** ______________________________________________

**Provider Number:** ___________ **Phone ext:** ________ **Date:** ______________

**Signature:** ________________________________________________________

**Indication for study:** ______________________________________________________

**Clinical Details:** __________________________________________________

______________________________________________________________________

**Co-existing Conditions:**

- ☐ Asthma
- ☐ Chronic Lung Disease
- ☐ Neuromuscular Disease
- ☐ Scoliosis
- ☐ Developmental Delay
- ☐ Other ________________________

**Medications:** ______________________________________________

**Specific Requirements:**

- ☐ Oximetry to be performed in room air
- ☐ Oximetry to be performed in O2 at ____ l/min
- ☐ Alarms to be switched off (OSA patients)

OR

- ☐ Set Sa02 alarm at: ________(usually 88%) and
- ☐ Low heart rate alarm at:_______(usually 90 bpm)

**Changes to be made during the study:**

- ☐ Nil
- ☐ If SaO2 drops below _______ commence oxygen at ____ l/min

**RCH@Home Use Only:** ***Please sign and initial***

| Today's Date | | | | | |
|---|---|---|---|---|---|
| Verbal Consent | | | | | |
| OH&S | | | | | |
| Drop off Date | | Drop off Time | | Pick up Date | |

1. Please fill in the **request form** completely - if not completed adequately it will be returned for more information and hence may add to the waiting time
2. Please fill in the additional admission request form and **make sure** you select **category "1" (within 30 days)**

NB: If patient is under 2 yrs or has symptoms of severe obstruction, we will try to do these within two weeks.

3. Please fax or send completed forms to RCH @ Home on 9345 6231
4. Test Results
    - will be reported in respiratory medicine within 2 weeks
    - will be emailed to requesting doctor and a copy sent to medical records
    - If you need urgent results call Respiratory Medicine ext. 5818/5844 and ask to speak with the respiratory nurse (Melissa or Sue-Ellen) or the respiratory fellow.

- **It is the responsibility of the requesting doctor to arrange appropriate follow up with the patient to enable results to be given and management planned**
- **Any patient who requires a full sleep study or does not have a hospital UR should be referred for a consultation in Respiratory Medicine.**

MR 71C

The **Royal Children's Hospital** Melbourne

UR NUMBER

SURNAME

GIVEN NAME(S)

DATE OF BIRTH

AFFIX PATIENT LABEL HERE

# Admission Clinical Details

**This form must be used for both medical and surgical admissions**

- Please ensure the completed MR138 Health Questionnaire is attached to this form

**Unit:** **Consultant:**

## Clinical details

Provisional diagnosis:

Procedure/s to be performed:

Consent signed? ☐ Yes ☐ No ☐ Not applicable

Allergies, e.g. latex / drug sensitivities: ☐ Yes (if yes, please specify) ☐ Nil known

Image intensifier required? ☐ Yes ☐ Other special equipment required:

**Medical history:** (including surgical and anaesthesia risks, e.g. diabetic, anaesthetic history)

Estimated duration of procedure: ______ hours ______ minutes

Does the patient require a pre-admission assessment? ☐ No ☐ Yes (please specify and arrange) ______

**Admission assessment** (booking surgeon/proceduralist to tick admission requirement)

| ☐ **Option 1: Day stay patient** | ☐ **Option 2: Overnight stay** | ☐ **Option 3: Overnight stay with comorbidities** |
|---|---|---|
| • No RMO admit | • No RMO admit | • RMO admit |

**Blood for crossmatch must be taken the day before surgery**

☐ Group and Hold only **OR** ☐ Cross-match No. of units ______

## Booking details

| | Referral: | Waiting list category: | Insurance status: |
|---|---|---|---|
| ☐ Child can be admitted at 24 hours notice | ☐ 1. Private | ☐ **1) Most urgent** <30 days | ☐ Public |
| Length of stay: ☐ Day only ____ No. nights | ☐ 2. Other hospital | ☐ **2) Urgent** >30 days <90 days | ☐ Private insured |
| Admit via: ☐ Day centre ☐ Admissions | ☐ 3. RCH Outpatients | ☐ **3) Not urgent** | ☐ Private non-insured |
| | ☐ 4. Other RCH department | | ☐ TAC |
| | ☐ 5. Other outside source | | ☐ International |

**Date of admission** ______ ☐ am ☐ pm (if known) **Date of operation** ______ ☐ am ☐ pm (if known)

**Date:** **Doctor's name:** **Signature:**

**Fax this form to (03) 9345 6202 or deliver to Admissions to book in**

Stock No. 502871, ERC 090099, Feb 2009

**Admission Clinical Details MR 71C**