The Royal Children's Hospital Melbourne

WALLABY WARD REFERRAL:
RCH External Overnight Oximetry Request

Hospital In The Home **Date**:_____

Please scan and email all referrals to Hospital in the Home at: Wallaby.admin@rch.org.au

NOTE: IF PATIENT IS IN NORTHERN OR MONASH CHILDREN'S HOSPITAL CATCHMENT THIS REFERRAL WILL BE REJECTED. PLEASE REFER TO EITHER SERVICE DIRECTLY.

Patient Details:

Patient surname:	Given name:
Date of birth:	RCH MRN (if known to RCH):
Gender:	
Address:	
Suburb:	Postcode:
Eligible for Medicare? ◯ Yes ◯ No	Medicare Number __ __ __ __-__ __ __ __ __-__ /__
Health Care Card Number:	
Indigenous status: ◯ Aboriginal ◯ Torres Strait Islander ◯ Not Indigenous	
Does the patient speak English? ◯ Yes ◯ No	
If no, what is primary language?	
Who does the patient live with?	
Where will the oximeter testing take place?	
Child protection involvement? ◯ Yes ◯ No If yes, worker contact details:	
Parent/carer name:	
Parent/carer phone number:	
Does the parent/carer speak English? ◯ Yes ◯ No	
If no, what is primary language?	
Does the parent/carer hold parental responsibility for the patient? ◯ Yes ◯ No	
If no, who holds parental responsibility and can consent for treatment? Name: Phone number: Relationship: Has this person consented to referral for oximetry testing? ◯ Yes ◯ No	

Reason for Referral

ONLY REFERRALS FROM PAEDIATRICIANS AND ENT SURGEONS WILL BE ACCEPTED

◯ Clinical diagnosis of OSA ◯ Other reason: _____

_____

● **URGENT:** ◯ **YES /** ◯ **NO** Reason: _____

If patient also requires referral to respiratory or sleep clinic for consideration of a full polysomnography study a separate referral must be sent to the relevant department.

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Referring Doctor Details:

Name:	Provider No:
Email address:	
Address:	
Phone:	Fax:
Signature:	Date: / /

Contact details/fax number for GP/ENT/Paediatrician if referrer would like results copied to them:

_____

Notes for referrer:

1. Test results:
   i. Will be reported within 2-4 weeks from date oximetry is performed, depending on service demands.
   ii. Will be faxed to requesting doctor and a copy sent to the RCH electronic medical record.
   iii. Can by copied to GP/Paediatrician/ENT if details/fax number are provided above.

Clinical Details (Please mark all that apply to assist with triage):

◯ Snoring > 3 nights/week	◯ Apnoeas	◯ Choking/gasping in sleep
◯ Breathing difficulties in sleep	◯ Restless sleep	◯ Excessive daytime sleepiness
◯ Aggression/poor concentration	◯ Mouth breathing	◯ Behavioural concerns/hyperactivity
◯ Frequent URTI/nasal discharge	◯ Large tonsils	◯ Congested turbinates
◯ Allergic rhinitis	◯ Overweight/obese	

Additional Medical History/ENT Surgery/Co-Existing Conditions:

_____

_____

_____

_____

_____

Current Medications:

● Nasal steroid use: Current: ◯ Yes / ◯ No Previous: ◯ Yes / ◯ No