# WALLABY WARD REFERRAL: RCH External Overnight Oximetry Request Form

**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: | 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: | |
| Are there any current legal orders for this child? Yes / No Details: | |
| Other support services involved? Yes / No Details: | |
| Parent/carer name: | |
| Parent/ carer phone number: | |
| Does the parent/carer speak English? Yes / No | |
| If no, what is the 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?<br>Name: Phone number:<br>Relationship:<br>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.

**REFERRING DOCTOR DETAILS:**

**NAME:**_____ **Provider No:**_____

**EMAIL ADDRESS:**_____

**ADDRESS:**_____

**PHONE:**_____**FAX:**_____**SIGNATURE:**_____

**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 be copied to GP/Paediatrician/ENT if details/fax 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