The Royal Children's Hospital Melbourne

WALLABY WARD REFERRAL:
RCH External Overnight Oximetry Request

Hospital In The Home/Respiratory and Sleep Medicine **Date**:_____

Please scan and email all referrals to our Hospital in The Home team on: Wallaby.admin@rch.org.au

Patient Details

Patient surname:	Given name:
Date of birth:	RCH MRN:
Gender: ○ Male ○ Female	○ Other:
Address:	Postcode
Parent/Carer surname:	Given name:
Mobile number:	Landline number:
Medicare number:	○ Not eligible for Medicare
Indigenous status: ○ Aboriginal ○ Torres Strait Islander ○ Not Indigenous	
Interpreter required: ○ Yes ○ No	Language:

Reason for Referral

○ Clinical diagnosis of OSA ○ Other reason: _____

○ Oximetry only AND follow up with referring clinician

○ Oximetry with follow up by referring clinician AND referral to: ○ respiratory or ○ sleep clinic for consideration of sleep study

● **URGENT: YES / NO** Reason: _____

Referring Doctor Details

Name:	Provider Number:
Email address:	
Practice address:	
Telephone number:	Fax Number:
Signature:	Date: / /

Notes for referrer: Scan and email referrals to Wallaby.admin@rch.org.au

1. It is the responsibility of the **REQUESTING DOCTOR** to arrange appropriate follow up with the patient to enable timely delivery of results and management planning**.**
2. Please include **DETAILED HISTORY** on page 2 for optimal reporting**.**
3. If patient is < 2 years or has symptoms of severe obstruction please request an **URGENT** test.
4. **Test results:**
   i. Will generally be reported by Respiratory/HITH teams within 2 weeks from date oximetry is performed.
   ii. Will be faxed to the requesting doctor and a copy sent to the RCH electronic medical record.
   iii. Contact the Nurse Co-ordinator, Oximetry and Sleep Department, Respiratory Medicine for urgent results on phone 9345 5818 and if unanswered, leave a message.

RCH External Overnight Oximetry Request

Patient Name:_____

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

Medical History / Co-existing Conditions:

○ Previous upper airway surgery (specify):_____

○ Neurological/neuromuscular condition:_____

○ Syndrome: ○ Down syndrome ○ Pierre-Robin ○ Cleft Palate ○ Craniofacial

○ Mucopolysacchariodoses ○ Other:_____

○ Laryngomalacia ○ Other upper airway pathology:_____

○ Cardiovascular/respiratory disease:_____

○ Age < 2 years ○ Obesity: BMI (kg/m^2):_____ (Ht:_____ Wt:_____)

○ Clinical concern of reflux ○ Risk of aspiration

○ Ex-premature infant: ● Chronic lung disease: Yes / No ● O2 weaning: Yes / No

Current Medications:

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

Specific Requirements for Oximetry:

○ Oximetry to be performed in air ○ Oximetry to be performed in oxygen at ____ l/min

○ Alarms to be switched off (OSA patients)

OR

○ Set SaO2 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