

*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:

<u>Indications for Study:</u>	<u>Specific Tests / Requirements:</u>	<u>Special Needs:</u>
<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 to Jayne McKeown: (03) 9594 6224