

ENT Rooms Pre-admission Clinic ENT
Number:.....

- | | |
|---|--|
| <input type="checkbox"/> Dandenong Hospital | <input type="checkbox"/> Monash Medical Centre Clayton |
| <input type="checkbox"/> Kingston Centre | <input type="checkbox"/> Monash Medical Centre Moorabbin |
| <input type="checkbox"/> Dandenong Hospital | <input type="checkbox"/> Community Health Services |
| <input type="checkbox"/> Casey Hospital | <input type="checkbox"/> Cranbourne Integrated Care Centre |

Outpatients Unit Record

Surname:.....
Given name:.....
D.O.B..... Age: Sex:
Affix Patient Identification Label

CONSULTATION BY

Melbourne Children's Sleep Centre

REQUESTED BY

ENT Clinic

REASON

- For opinion For Transfer Joint Care For a procedure

CLINICAL SUMMARY AND REQUEST

OXIMETRY REQUEST FROM MCSU

Diagnosis: Clinical diagnosis of OSA Other reason:

Medical History:

- Neurological /neuromuscular conditions (i.e. Cerebral Palsy, Duchenne MD)

Syndrome: Down Syndrome Pierre Robin Mucopolysaccharidoses
 Craniofacial Syndrome Cleft Palate surgery
 Other:

- Obesity
 Cardiovascular / Respiratory Disease:
 Previous upper airway trauma / surgery:

Planned Surgery: Type: Category: 1 2 3

Referring Doctor Name: Provider No:

Signature Print Name Date

CONSULTANT OPINION

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.....

Name & Contact Details of Consultant in Charge:.....

**Please fax oximetry request form to: Nina Lyons, Secretary,
Fax: 9594 6224
Queries Ph: 9594 5671**