melbourne children's sleep centre

Monash Children's
Southern Health

Melbourne Children's Sleep Centre

OXIMETRY REQUEST

PATIENT DETAILS

Name: ……………………………………………………………………………………………

Address: ……………………………………………………………………………………………

……………………………………………………………………………………………

Date of Birth: … / /………Tel: ………………………Mob: ………………………

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: ___________________

Address: ____

Phone: ____________________________ Fax: ______________________________

Name & Contact Details of Consultant in Charge: _____________________________________

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Please fax oximetry request form to:

Nina Lyons, Secretary **Fax: 9594 6224**

Queries **Ph: 9594 5671**