Health Services Programs
Outpatient Redesign Project

Respiratory & Sleep Medicine paediatric
Clinical Prioritisation Criteria (CPC)

Outpatient Referral Criteria

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Respiratory & Sleep Medicine (paediatric) conditions

Please note this is not an exhaustive list of all conditions for outpatient services and does not exclude consideration for referral unless specifically stipulated in the exclusions section.

- asthma
- chronic cough
- cystic Fibrosis (CF)
- dyspnoea (shortness of breath)
- haemoptysis
- recurrent respiratory infections
- sleep disordered breathing (including sleep apnoea, sleep difficulties)
- stridor

Exclusions for public specialist outpatient services

Not all Respiratory & Sleep Medicine conditions (paediatric) are appropriate for referral into the South Australian public health system. The following are not routinely provided in a public specialist outpatient service:

- asthma without first-line management in line with the Australian Asthma Handbook
- bronchiolitis – refer to emergency department if concerns of respiratory distress
- nasal epistaxis for consideration of nasal cautery (or reassurance if case is mild)
- haemoptysis related to tobacco smoking, marijuana use and vaping

Emergency information

See the individual condition pages for more specific emergency information.

Feedback

We welcome your feedback on the Clinical Prioritisation Criteria and website, please email us any suggestions for improvement at Health.CPC@sa.gov.au.

Review

The Rheumatology (paediatric) CPC is due for review in *DDMM* 2026.

Evidence statement

See Respiratory & Sleep Medicine (paediatric) evidence statement *(evidence statement to be linked here).*

This document is for consultation only.

Asthma

Referral to emergency

If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

- severe uncontrolled asthma
- acute exacerbation of asthma not responding to therapy
- asthma with any of the following concerning features
  - coexistent pneumothorax
  - pneumonia
  - signs of respiratory distress
  - if the patient has a silent chest, cardiovascular compromise, relative bradycardia or decreasing rate and depth of breathing, these are all signs of an impending respiratory arrest and require urgent medical attention.
- respiratory distress leading to
  - cyanosis
  - dyspnoea
  - tachypnoea
  - intercostal/subcostal retractions
  - tracheal tug
- haemodynamic instability

Please contact the paediatric medicine registrar on-call to discuss your concerns prior to referral.

Contacts for clinical advice

For clinical advice, please telephone the relevant metropolitan Local Health Network switchboard and ask to speak to the relevant specialty service.

Asthma Australia (Asthma Educators) Mon-Fri 9-5pm (AEST)

- 1800 278 462 (1800 ASTHMA)
- Email: asthmasupport@asthma.org.au

Metropolitan Local Health Networks

Southern Adelaide Local Health Network

- Flinders Medical Centre (08) 8204 5511

Women's and Children's Hospital Network

- Women's and Children's Hospital (08) 8161 7000

Inclusions, exclusions, and triage categories

Inclusions

- complex asthma presentations

Exclusions

- asthma without first-line management in line with the Australian Asthma Handbook
- bronchiolitis – refer to emergency department if concerns of respiratory distress

Triage categories

Category 1 (appointment clinically indicated within 30 days)

- recent history of severe or life-threatening respiratory illness history in the past 12 months requiring ventilation or intensive care admission
- asthma with unexplained clinical findings e.g., focal signs, abnormal voice or cry, dysphagia, inspiratory stridor

Category 2 (appointment clinically indicated within 90 days)

- recurrent asthma attacks (≥ 3 per year) requiring hospitalisation or steroids in the last 12 months.
- asthma with inadequate control despite conventional treatment (particularly inhaled corticosteroids above 250 micrograms per day of fluticasone propionate equivalent)
- uncertainty about diagnosis of asthma

Category 3 (appointment clinically indicated within 365 days)

- nil

Referral information

For information on referral forms and how to import them, please view general referral information.

Essential referral information

Completion required before first appointment to ensure patients are ready for care. Please indicate in the referral if the patient is unable to access mandatory tests or investigations as they incur a cost or are unavailable locally.

- identifies as Aboriginal and/or Torres Strait Islander
- identify within your referral if you feel your patient is from a vulnerable population, under guardianship/out-of-home care arrangements and/or requires a third party to receive correspondence on their behalf
- interpreter requirements
- number and nature of asthma exacerbations, including any severe asthma attacks requiring hospital or intensive care admissions
- severity and frequency of symptoms including any sleep, feeding or exercise related symptoms
- severity and frequency of interval symptoms
- symptom triggers (e.g., cold air, exercise, pollens, viral infections)
- current and previous growth parameters including weight, length/height and head circumference.
- current and previous medications
- extent of school absenteeism or limitation in daily function
- copy of asthma action plan

Additional information to assist triage categorisation

- consider spirometry if patient is > 6 years old
- assessment of adherence to medication
- immunisation, developmental and medical history
- history of atopy/allergic disease and family history of same

Clinical management advice and resources

Clinical management advice

- optimise asthma therapy in line with the Australian Asthma Handbook, including assessment of device technique and adherence to treatment
- develop an asthma action plan
- treat allergic rhinitis if present, as this can exacerbate asthma symptoms
- avoid certain medications, such as aspirin, nonsteroidal anti-inflammatory drugs, beta-blockers and 'natural remedies' such as echinacea or royal jelly that may cause allergic reaction.
- if patient does not meet inclusion criteria for referral to Paediatric Respiratory & Sleep Medicine, consider referral to Paediatric General Medicine
- Paediatric Allergy & Immunology accept referrals from respiratory physicians for consideration of allergen immunotherapy.

Clinical resources

- National Asthma Council Australia – Australian Asthma Handbook
- The Royal Children's Hospital Melbourne – Clinical Practice Guidelines: Acute Asthma

Consumer resources

- The Royal Children's Hospital Melbourne – Kids Health Information Fact Sheet: Asthma
- The Royal Children's Hospital Melbourne – Kids Health Information Fact Sheet: Asthma – videos

Key Words

Asthma, breathing, difficulty, wheeze, inhaler, puffer, steroids

Chronic Cough

Referral to emergency

If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

- inhaled foreign body.
- respiratory distress leading to
  - apnoeic episode
  - cyanosis
  - dyspnoea
  - intercostal/subcostal retractions
  - tracheal tug
  - reduction of feeding volume, particularly in infants and young children with signs of clinical dehydration
  - stridor
- haemodynamic instability

Please contact the paediatric medicine registrar on-call to discuss your concerns prior to referral.

Contacts for clinical advice

For clinical advice, please telephone the relevant metropolitan Local Health Network switchboard and ask to speak to the relevant specialty service.

Southern Adelaide Local Health Network

- Flinders Medical Centre (08) 8204 5511

Women's and Children's Hospital Network

- Women's and Children's Hospital (08) 8161 7000

Inclusions, exclusions, and triage categories

Inclusions

- bronchiectasis (non-cystic fibrosis)
- protracted bacterial bronchitis (PBB), defined as a pattern of daily wet cough for longer than 4 weeks duration which typically may occur after an initial viral illness, not responding to prolonged 2-week course of oral broad-spectrum antibiotics
- aspiration syndromes e.g. chronic/feed related aspiration
- non-resolution of a non-specific cough

Triage categories

Category 1 (appointment clinically indicated within 30 days)

- chronic cough with any of the following concerning features
  - systemic symptoms such as fever, weight loss, faltering growth
  - feeding difficulties (including choking or vomiting)
  - stridor and other respiratory noises
  - abnormal clinical respiratory examination including clubbing
  - abnormal chest x-ray (CXR)
  - history of haemoptysis

Category 2 (appointment clinically indicated within 90 days)

- episode of protracted bacterial bronchitis (PBB) not responding to empirical treatment with 2 weeks of broad-spectrum antibiotics
- recurrent pneumonia (≥ 2 per year)
- dry cough present for > 8 weeks with normal CXR and spirometry (if accessible) and no improvement following treatment trial (see 'clinical management advice')
- bronchiectasis (non-cystic fibrosis)
- aspiration syndromes e.g. chronic/feed related aspiration

Category 3 (appointment clinically indicated within 365 days)
- nil

Referral information

For information on referral forms and how to import them, please view general referral information.

Essential referral information
Completion required before first appointment to ensure patients are ready for care. Please indicate in the referral if the patient is unable to access mandatory tests or investigations as they incur a cost or are unavailable locally.
- identifies as Aboriginal and/or Torres Strait Islander
- identify within your referral if you feel your patient is from a vulnerable population, under guardianship/out-of-home care arrangements and/or requires a third party to receive correspondence on their behalf
- interpreter requirements
- symptoms including duration, severity, associated syncope, incontinence, shortness of breath, paroxysm-related symptoms such as vomiting or colour change
- presence or absence of concerning features
    - persistent fevers
    - night sweats
    - weight loss (include estimated amount)
    - haemoptysis
    - significant contacts with tuberculosis or pertussis
- detailed medical history including history of asthma, atopy, rhinitis, ear, nose and throat problems, gastro-oesophageal reflux disorder
- previous treatment and response
- results of chest x-ray (CXR), spirometry, sputum sample (in children with wet cough able to produce a sample) and/or any blood tests
- neonatal history including prematurity
- environmental factors such as tobacco smoke exposure
- weight and height/length
- developmental assessment
- coughing or gagging with oral intake
- family history of cystic fibrosis

Additional information to assist triage categorisation
- relevant allied health/diagnostic/imaging reports (including location of company and accession number)
- consider pulmonary function tests if patient is > 6 years old
- consider CXR if clinically indicated (e.g. suspicion of inhaled foreign body)
- symptoms including
    - any diurnal variation in severity (e.g. nocturnal or positional)
    - triggers (e.g. air temperature, food, talking, exercise)
    - swallowing difficulties
    - voice change
- spirometry pre and post bronchodilator (if able to access)

Clinical management advice and resources

Clinical management advice
- if suspected protracted bacterial bronchitis (PBB) (chronic wet cough with no signs or symptoms suggesting an alternative diagnosis):
    - treat with a 2–4-week course of oral antibiotics until resolution of wet cough
    - suggest empirical treatment with broad spectrum antibiotic such as amoxicillin/clavulanic acid 25mg/kg (max 875mg amoxicillin component) twice a day
    - If penicillin-allergic, consider azithromycin or co-trimoxazole
- if suspected asthma, offer trial of salbutamol to assess for a clinical response.

- if non-specific dry cough with normal chest x-ray +/- spirometry and no signs or symptoms suggesting a diagnosis, it may be appropriate to adopt a watchful waiting approach.
- evaluate exposure to tobacco smoke and other pollutants, as well as reviewing parental expectations and concerns.
- consider blood tests for respiratory serology (pertussis and mycoplasma) for chronic dry cough
- consider screening for immunodeficiency (baseline immunoglobulins) for chronic wet cough

Clinical resources

- Chronic suppurative lung disease and bronchiectasis in children and adults in Australia and New Zealand: A position statement from the Thoracic Society of Australia and New Zealand and The Australian Lung Foundation
- Management of bronchiectasis and CSPD in indigenous children and adults in remote and rural Australian communities
- Cough in Children and Adults: Diagnosis and Assessment. Australian Cough Guidelines summary statement
- The Royal Children's Hospital Melbourne – Clinical Practice Guidelines: Cough
- Thoracic Society of Australia & New Zealand (TSANZ) – Clinical Documents: Paediatric
- Position statement of the Thoracic Society of Australia and New Zealand. Cough in children: definitions and clinical evaluation

Consumer resources

- The Royal Children's Hospital Melbourne – Kids Health Information Fact Sheet: Bronchiolitis
- The Royal Children's Hospital Melbourne – Kids Health Information Fact Sheet: Cough

Key Words

Cough, bronchiectasis, protracted, bacterial, bronchitis, aspiration, foreign, body

Cystic Fibrosis (CF)

Referral to emergency

If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

- acute illness associated with cystic fibrosis.
- cystic fibrosis with any of the following concerning features:
  - respiratory distress
  - new haemoptysis (clots or more than streaks)
  - pleural effusion
  - consolidation/pneumonia/fever
  - non- response to antibiotics for chest infection

Please contact the paediatric medicine registrar on-call to discuss your concerns prior to referral.

Contacts for clinical advice

For clinical advice, please telephone the relevant metropolitan Local Health Network switchboard and ask to speak to the relevant specialty service.

Women's and Children's Hospital Network

- Women's and Children's Hospital (08) 8161 7000

Inclusions, exclusions, and triage categories

Triage categories

Category 1 (appointment clinically indicated within 30 days)

- newly diagnosed cystic fibrosis referred following newborn neonatal screening test, genetic labs or metabolic team following abnormal sweat test

Category 2 (appointment clinically indicated within 90 days)

- suspected but undiagnosed cystic fibrosis.

Category 3 (appointment clinically indicated within 365 days)

- nil

Referral information

For information on referral forms and how to import them, please view general referral information.

Essential referral information

Completion required before first appointment to ensure patients are ready for care. Please indicate in the referral if the patient is unable to access mandatory tests or investigations as they incur a cost or are unavailable locally.

- identifies as Aboriginal and/or Torres Strait Islander
- identify within your referral if you feel your patient is from a vulnerable population, under guardianship/out-of-home care arrangements and/or requires a third party to receive correspondence on their behalf
- interpreter requirements
- medications

Clinical management advice and resources

Clinical management advice

- RACGP – Cystic fibrosis

Clinical resources

- Cystic Fibrosis Western Australia (CFWA) – A Guide for Health Professionals

Consumer resources

- Cystic Fibrosis Australia

Key Words

Cystic, fibrosis, genetic, inherited, mucus

Dyspnoea (shortness of breath)

Referral to emergency

If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

- acute dyspnoea (if there are any other associated symptoms such as chest pain, fever, signs of respiratory distress, a chest x-ray is indicated with a clinical review with either a general practitioner or at the emergency department)

Please contact the paediatric medicine registrar on-call to discuss your concerns prior to referral.

Contacts for clinical advice

For clinical advice, please telephone the relevant metropolitan Local Health Network switchboard and ask to speak to the relevant specialty service.

Southern Adelaide Local Health Network
- Flinders Medical Centre (08) 8204 5511

Women's and Children's Hospital Network
- Women's and Children's Hospital (08) 8161 7000

Inclusions, exclusions, and triage categories

Triage categories

Category 1 (appointment clinically indicated within 30 days)
- nil

Category 2 (appointment clinically indicated within 90 days)
- unexplained chronic dyspnoea not requiring acute presentation to emergency department (see 'referrals to emergency')
- dyspnoea associated with exercise not responding to a trial of anti-asthma treatment

Category 3 (appointment clinically indicated within 365 days)
- nil

Referral information

For information on referral forms and how to import them, please view general referral information.

Essential referral information

Completion required before first appointment to ensure patients are ready for care. Please indicate in the referral if the patient is unable to access mandatory tests or investigations as they incur a cost or are unavailable locally.

- identifies as Aboriginal and/or Torres Strait Islander
- identify within your referral if you feel your patient is from a vulnerable population, under guardianship/out-of-home care arrangements and/or requires a third party to receive correspondence on their behalf
- interpreter requirements
- details and timeline of symptoms including variability and severity
- relevant medical conditions
- chest x-ray

Additional information to assist triage categorisation

- relevant allied health/diagnostic/imaging reports (including location of company and accession number)
- consider cardiac conditions as part of the differential diagnosis, refer accordingly and consider electrocardiogram/chest x-ray/blood pressure
- if able to access
    - lung function pre and post bronchodilator
    - pulse oximetry

Clinical management advice and resources

Clinical management advice

If the dyspnoea is long standing (i.e. greater than 4 weeks duration) or associated with exercise induced cough or wheeze, please consider asthma.

Clinical resources

- The Royal Children's Hospital Melbourne – Assessment of severity of respiratory conditions

Consumer resources

- Elsevier – Shortness of breath, paediatric

Key Words

Dyspnoea, shortness, of, breath, SOB, breathless, breathlessness, short, of, breath, out, of breath,

Haemoptysis

Referral to emergency

If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

- significant haemoptysis
- any haemoptysis with acute dyspnoea, measured hypoxia, altered consciousness, hypotension, tachycardia or chest pain

Please contact the paediatric medicine registrar on-call to discuss your concerns prior to referral.

Contacts for clinical advice

For clinical advice, please telephone the relevant metropolitan Local Health Network switchboard and ask to speak to the relevant specialty service.

Southern Adelaide Local Health Network

- Flinders Medical Centre (08) 8204 5511

Women's and Children's Hospital Network

- Women's and Children's Hospital (08) 8161 7000

Inclusions, exclusions and triage categories

Exclusions

- nasal epistaxis for consideration of nasal cautery (or reassurance if case is mild)
- haemoptysis related to tobacco smoking, marijuana use and vaping

Triage categories

Category 1 (appointment clinically indicated within 30 days)

- intermittent haemoptysis over a 4-week period

Category 2 (appointment clinically indicated within 90 days)

- nil

Category 3 (appointment clinically indicated within 365 days)

- nil

Referral information

For information on referral forms and how to import them, please view general referral information.

Essential referral information

Completion required before first appointment to ensure patients are ready for care. Please indicate in the referral if the patient is unable to access mandatory tests or investigations as they incur a cost or are unavailable locally.

- identifies as Aboriginal and/or Torres Strait Islander
- identify within your referral if you feel your patient is from a vulnerable population, under guardianship/out-of-home care arrangements and/or requires a third party to receive correspondence on their behalf
- interpreter requirements
- comorbidities
- medication list (particularly anticoagulants)
- recent clinical events (particularly viral symptoms, infective bronchitis)
- full blood count and coagulation screen results
- chest x-ray

Additional information to assist triage categorisation

- relevant allied health/diagnostic/imaging reports (including location of company and accession number)

Clinical management advice and resources

Clinical management advice

True haemoptysis is rare in children and adolescents. The most common cause of haemoptysis is nasal epistaxis, which can be managed by general practitioners (consider referral to Paediatric Ear, Nose and Throat if concerned). Please consider asking about illicit behaviours such as tobacco smoking, marijuana use and vaping and recommend discontinuation if occurring. If epistaxis and illicit behaviours can be excluded, a referral to Paediatric Respiratory Medicine is warranted.

Clinical resources

- UpToDate – Haemoptysis in children\

Key Words

Haemoptysis, blood, bleeding

Recurrent respiratory infections

Referral to emergency

If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

- nil

Contacts for clinical advice

For clinical advice, please telephone the relevant metropolitan Local Health Network switchboard and ask to speak to the relevant specialty service.

Southern Adelaide Local Health Network

- Flinders Medical Centre (08) 8204 5511

Women's and Children's Hospital Network

- Women's and Children's Hospital (08) 8161 7000

Inclusions, exclusions and triage categories

Triage categories

Category 1 (appointment clinically indicated within 30 days)

- nil

Category 2 (appointment clinically indicated within 90 days)

- more than 3-4 presentations of lower respiratory infections requiring antibiotics in the past 12 months

Category 3 (appointment clinically indicated within 365 days)

- nil

Referral information

For information on referral forms and how to import them, please view general referral information.

Essential referral information

Completion required before first appointment to ensure patients are ready for care. Please indicate in the referral if the patient is unable to access mandatory tests or investigations as they incur a cost or are unavailable locally.

- identifies as Aboriginal and/or Torres Strait Islander
- identify within your referral if you feel your patient is from a vulnerable population, under guardianship/out-of-home care arrangements and/or requires a third party to receive correspondence on their behalf
- interpreter requirements
- description of lower respiratory tract symptoms with supporting investigations e.g. chest x-ray, sputum culture, white cell count
- details of antibiotics previously prescribed for respiratory tract infections

Additional information to assist triage categorisation

- relevant allied health/diagnostic/imaging reports (including location of company and accession number)

Clinical management advice and resources

Clinical management advice

- if child experiences symptoms of an upper respiratory tract infection with a cough which lasts < 4 weeks and resolves spontaneously, no further assessment or treatment is needed
- if suspected protracted bacterial bronchitis (PBB) (chronic wet cough with no signs or symptoms suggesting an alternative diagnosis):
    - treat with a 2–4-week course of oral antibiotics until resolution of wet cough
    - suggest empirical treatment with broad spectrum antibiotic such as amoxicillin/clavulanic acid 25mg/kg (max 875mg amoxicillin component) twice a day
    - if penicillin-allergic, consider azithromycin or co-trimoxazole
    - if the child has experienced ≥ 3 episodes of PBB within the last 12 months, consider referral to Paediatric Respiratory Medicine for evaluation of any underlying or predisposing conditions.

Clinical resources

- Thoracic Society of Australia & New Zealand (TSANZ) – Clinical Documents: Paediatric

Consumer resources

- The Royal Children's Hospital Melbourne – Kids Health Information Face Sheet: Pneumonia

Key Words

Recurrent, respiratory, infection

Sleep disordered breathing (including sleep apnoea, sleep difficulties)

Referral to emergency

If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

- nil

Please contact the on-call registrar at your local Local Health Network (see 'contacts for clinical advice') to discuss clinical concerns (e.g. prolonged apnoeas, cyanosis, altered level of consciousness or significant and escalating parental concerns).

Contacts for clinical advice

For clinical advice, please telephone the relevant metropolitan Local Health Network switchboard and ask to speak to the relevant specialty service.

Southern Adelaide Local Health Network

- Flinders Medical Centre (08) 8204 5511

Women's and Children's Hospital Network

- Women's and Children's Hospital (08) 8161 7000

Inclusions, exclusions, and triage categories

Triage categories

Category 1 (appointment clinically indicated within 30 days)

- infant with observed prolonged apnoeas

Category 2 (appointment clinically indicated within 90 days)

- recurrent snoring with associated symptoms such as apnoeas, restless sleep, mouth breathing, daytime tiredness or headaches, poor concentration requiring objective evaluation to confirm the evidence of obstructive sleep apnoea
- recurrent snoring in children with risk factors for obstructive sleep apnoea (e.g. obesity, hypotonia, facial dysmorphology, specific syndromes like Trisomy 21)

Category 3 (appointment clinically indicated within 365 days)

- nil

Referral information

For information on referral forms and how to import them, please view general referral information.

Essential referral information

Completion required before first appointment to ensure patients are ready for care. Please indicate in the referral if the patient is unable to access mandatory tests or investigations as they incur a cost or are unavailable locally.

- identifies as Aboriginal and/or Torres Strait Islander
- identify within your referral if you feel your patient is from a vulnerable population, under guardianship/out-of-home care arrangements and/or requires a third party to receive correspondence on their behalf
- interpreter requirements

- history:
    - past medical/surgical history
    - onset, duration, and progression of symptoms, including:
        - parental observations and description of sleep patterns
            - snoring
            - restlessness
            - snorting arousals or apnoeic episodes
            - disturbed sleep, night terrors
            - enuresis, bruxism
        - daytime symptoms
            - hypersomnolence
            - irritability
            - hyperactivity
            - poor school performance
    - management history including treatments trialled/implemented prior to referral
    - current medication list including non-prescription medication, herbs and supplements
- examination:
    - body mass index
    - large tonsils
    - nasal obstruction
    - craniofacial abnormality
- consider six-week trial of nasal steroids

Additional information to assist triage categorisation

- relevant allied health/diagnostic/imaging reports (including location of company and accession number)
- tonsillar hypertrophy grading scale

Clinical management advice and resources

Clinical management advice

For clinical management advice regarding obstructive sleep apnoea/snoring, please refer to the Paediatric Ear, Nose and Throat Clinical Prioritisation Criteria.

If a child has other sleep related concerns such as difficulty with sleep onset, frequent overnight awakenings, please consider techniques to improve sleep hygiene. If symptoms persist beyond 3 months, refer to Paediatric Respiratory & Sleep Medicine.

If child has unpleasant behaviours in sleep (e.g. night terrors, nightmares, sleepwalking, headbanging, bruxism), please ask if child has any recollections of such episodes to determine if these symptoms are occurring in the “awake” or “sleep” phase. If the child has no recollections of such episodes, reassure the family that these episodes are benign and improve beyond the preschool years.

If a child or adolescent has symptoms of excessive sleep (beyond normal standard hours for age group) please refer to Paediatric Respiratory & Sleep Medicine.

Clinical resources

- Australasian Sleep Association – Health professionals information
- Australian Family Physician - Tonsillotomy: An alternative surgical option to total tonsillectomy in children with obstructive sleep apnoea
- HealthPathways SA

Consumer resources

- Perth Children's Hospital – Child Health Facts: Obstructive Sleep apnoea in Children & Management
- The Royal Children's Hospital Melbourne – Kids Health Information Face Sheet: Obstructive sleep apnoea (OSA)
- Sleep Health Foundation – All Factsheets
- Lung Foundation Australia – Obstructive Sleep Apnoea fact sheet

Key Words

Snoring, sleep, apnea, obstructive sleep apnea, disordered breathing

Stridor

Referral to emergency

If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

- if the stridor is acute, please refer to the emergency department if there are signs of respiratory distress, fevers or "stridor at rest."
- if the wheezing is acute, consider acute bronchiolitis and foreign body aspiration and refer to emergency department if there is signs of respiratory distress or history of inhalation

Please contact the paediatric medicine registrar on-call to discuss your concerns prior to referral.

Contacts for clinical advice

For clinical advice, please telephone the relevant metropolitan Local Health Network switchboard and ask to speak to the relevant specialty service.

Southern Adelaide Local Health Network

- Flinders Medical Centre (08) 8204 5511

Women's and Children's Hospital Network

- Women's and Children's Hospital (08) 8161 7000

Inclusions, exclusions, and triage categories

Inclusions

- Stridor not requiring referral to emergency department (see 'referral to emergency')

Triage categories

Category 1 (appointment clinically indicated within 30 days)

- stridor in infants < 3 months of age
- evidence of biphasic stridor (stridor occurring with both inspiratory and expiratory phases of breathing)
- stridor with poor growth
- referrals from Paediatric Ear, Nose and Throat post flexible nasoendocopsy confirming upper airway pathology

Category 2 (appointment clinically indicated within 90 days)

- mild stridor without feeding difficulties

Category 3 (appointment clinically indicated within 365 days)

- nil

Referral information

For information on referral forms and how to import them, please view general referral information.

Essential referral information

Completion required before first appointment to ensure patients are ready for care. Please indicate in the referral if the patient is unable to access mandatory tests or investigations as they incur a cost or are unavailable locally

- identifies as Aboriginal and/or Torres Strait Islander
- identify within your referral if you feel your patient is from a vulnerable population, under guardianship/out-of-home care arrangements and/or requires a third party to receive correspondence on their behalf
- interpreter requirements

Additional information to assist triage categorisation

- relevant allied health/diagnostic/imaging reports (including location of company and accession number)
- feeding quality

Clinical management advice and resources

Clinical management advice

- both Paediatric Respiratory Medicine and Paediatric Ear, Nose and Throat departments typically see all children with stridor as a category 1, and work in parallel to manage these patients
- if the stridor is mild, present from birth and the child is thriving, referrals can be directed to Paediatric Ear, Nose and Throat and/or Paediatric Respiratory Medicine for evaluation
- if there are any signs of respiratory distress and the child is not thriving, please refer to Paediatric Respiratory Medicine for further evaluation

Clinical resources

- Australian Family Physician – The wheezing child: an algorithm

Consumer resources

- Perth Children's Hospital – Child Health Facts: The wheezing child
- Perth Children's Hospital – Child Health Facts: Wheezing or noisy breathing – Keeping our Mob Healthy
- ENT UK – Tracheomalacia in children

Key Words

Noisy, breathing, wheeze, stridor, tracheomalacia, bronchomalacia, laryngomalacia