



Service: Otolaryngology Pediatric

Care Venue: HSC Childrens Maples | TGH

Case Details <small>*all fields are mandatory in Novari ATC</small>	Patient Name*:		DOB: MM/DD/YYYY																			
	PHIN*:																					
Diagnosis Category*																						
<table border="0" style="width: 100%;"> <tr> <td><input type="checkbox"/> [C] Known Cancer</td> <td><input type="checkbox"/> DISORDERS OF THE NOSE AND SEPTUM</td> </tr> <tr> <td><input type="checkbox"/> [C] Suspected Cancer</td> <td><input type="checkbox"/> DISORDERS OF THE SALIVARY GLANDS</td> </tr> <tr> <td><input type="checkbox"/> BENIGN TUMOURS</td> <td><input type="checkbox"/> FOREIGN BODIES</td> </tr> <tr> <td><input type="checkbox"/> DISEASE OF RESPIRATORY SYSTEM</td> <td><input type="checkbox"/> INFECTIVE OR INFLAMMATORY DISEASES OF THE EAR</td> </tr> <tr> <td><input type="checkbox"/> DISEASES OF THE ENDOCRINE SYSTEM</td> <td><input type="checkbox"/> INFECTIVE OR INFLAMMATORY DISEASES OF THE NOSE AND SINUSES</td> </tr> <tr> <td><input type="checkbox"/> DISEASES OF THE NERVOUS SYSTEM</td> <td><input type="checkbox"/> OSSICULAR CHAIN DISORDER</td> </tr> <tr> <td><input type="checkbox"/> DISEASES OF THE PHARYNX, TONSILS AND ADENOIDS</td> <td><input type="checkbox"/> OTHER OTOLARYNGOLOGIC DIAGNOSES</td> </tr> <tr> <td><input type="checkbox"/> DISEASES OF THE UPPER GI TRACT</td> <td><input type="checkbox"/> OTOSCLEROSIS AND OTHER DISORDERS OF HEARING</td> </tr> <tr> <td><input type="checkbox"/> DISORDERS OF THE MOUTH</td> <td><input type="checkbox"/> TRAUMA</td> </tr> </table>					<input type="checkbox"/> [C] Known Cancer	<input type="checkbox"/> DISORDERS OF THE NOSE AND SEPTUM	<input type="checkbox"/> [C] Suspected Cancer	<input type="checkbox"/> DISORDERS OF THE SALIVARY GLANDS	<input type="checkbox"/> BENIGN TUMOURS	<input type="checkbox"/> FOREIGN BODIES	<input type="checkbox"/> DISEASE OF RESPIRATORY SYSTEM	<input type="checkbox"/> INFECTIVE OR INFLAMMATORY DISEASES OF THE EAR	<input type="checkbox"/> DISEASES OF THE ENDOCRINE SYSTEM	<input type="checkbox"/> INFECTIVE OR INFLAMMATORY DISEASES OF THE NOSE AND SINUSES	<input type="checkbox"/> DISEASES OF THE NERVOUS SYSTEM	<input type="checkbox"/> OSSICULAR CHAIN DISORDER	<input type="checkbox"/> DISEASES OF THE PHARYNX, TONSILS AND ADENOIDS	<input type="checkbox"/> OTHER OTOLARYNGOLOGIC DIAGNOSES	<input type="checkbox"/> DISEASES OF THE UPPER GI TRACT	<input type="checkbox"/> OTOSCLEROSIS AND OTHER DISORDERS OF HEARING	<input type="checkbox"/> DISORDERS OF THE MOUTH	<input type="checkbox"/> TRAUMA
<input type="checkbox"/> [C] Known Cancer	<input type="checkbox"/> DISORDERS OF THE NOSE AND SEPTUM																					
<input type="checkbox"/> [C] Suspected Cancer	<input type="checkbox"/> DISORDERS OF THE SALIVARY GLANDS																					
<input type="checkbox"/> BENIGN TUMOURS	<input type="checkbox"/> FOREIGN BODIES																					
<input type="checkbox"/> DISEASE OF RESPIRATORY SYSTEM	<input type="checkbox"/> INFECTIVE OR INFLAMMATORY DISEASES OF THE EAR																					
<input type="checkbox"/> DISEASES OF THE ENDOCRINE SYSTEM	<input type="checkbox"/> INFECTIVE OR INFLAMMATORY DISEASES OF THE NOSE AND SINUSES																					
<input type="checkbox"/> DISEASES OF THE NERVOUS SYSTEM	<input type="checkbox"/> OSSICULAR CHAIN DISORDER																					
<input type="checkbox"/> DISEASES OF THE PHARYNX, TONSILS AND ADENOIDS	<input type="checkbox"/> OTHER OTOLARYNGOLOGIC DIAGNOSES																					
<input type="checkbox"/> DISEASES OF THE UPPER GI TRACT	<input type="checkbox"/> OTOSCLEROSIS AND OTHER DISORDERS OF HEARING																					
<input type="checkbox"/> DISORDERS OF THE MOUTH	<input type="checkbox"/> TRAUMA																					
If Cancer*: <input type="checkbox"/> Diagnostic <input type="checkbox"/> Treatment <input type="checkbox"/> Reconstruction <input type="checkbox"/> Prophylactic <input type="checkbox"/> Staging <input type="checkbox"/> Surveillance <input type="checkbox"/> Palliative																						
Please refer to the Case Priority Criteria to complete this section																						
Wait 2 Priority*: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5		Diagnosis Description:																				
Consented Procedure*:				Est. Procedure Time*: <small>Default value provided by system when available</small> ____ mins																		
Procedure Notes:																						
DTT*: MM/DD/YYYY	Laterality*: <small>(if applicable)</small> <input type="checkbox"/> Left <input type="checkbox"/> Right	Anesthetic*: <small>Regional sites only</small> <small>Anesthetist required</small> <input type="checkbox"/> Yes <input type="checkbox"/> No	Attend Short*: <small>Patient is available on short notice as a last-minute case replacement</small> <input type="checkbox"/> Yes <input type="checkbox"/> No	Admission Type*: <input type="checkbox"/> Day Surgery <input type="checkbox"/> Inpatient <input type="checkbox"/> Same Day Admit <input type="checkbox"/> Short Stay	Post Procedural Destination*: <small>Day Surgery</small> <input type="checkbox"/> ICU <input type="checkbox"/> Unit LOS: ____ days																	
Special Instructions:																						

Case Priority Criteria

Priority / Target Days	Diagnosis Description
1 (21 days)	P-CATS IIb Criteria <ul style="list-style-type: none"> <input type="checkbox"/> ACUTE RHINO SINUSITIS WITH ORBITAL/INTRACRANIAL INVOLVEMENT <input type="checkbox"/> BILATERAL CHOANAL ATRESIA <input type="checkbox"/> FOREIGN BODY ASPIRATION <input type="checkbox"/> LARYNGOMALACIA <input type="checkbox"/> LARYNGEAL STENOSIS WITH SIGNIFICANT AIRWAY ISSUES <input type="checkbox"/> MYCOBACTERIAL INFECTION: IF SKIN COMPROMISED <input type="checkbox"/> MALIGNANT NEOPLASM: TREATMENT <input type="checkbox"/> REMOVAL OF TONSILS AND/OR ADENOIDS: IF SEVERE OSA <input type="checkbox"/> REFLUX WITH ESOPHAGEAL STRICTURE
2 (42 days)	P-CATS III Criteria <ul style="list-style-type: none"> <input type="checkbox"/> DIAGNOSTIC ABR FOR HEARING LOSS <input type="checkbox"/> FOREIGN BODY REMOVAL-EAR <input type="checkbox"/> FOREIGN BODY REMOVAL - NOSE <input type="checkbox"/> LARYNGEAL STENOSIS WITHOUT SIGNIFICANT AIRWAY ISSUES <input type="checkbox"/> MYCOBACTERIAL INFECTION: OTHERWISE <input type="checkbox"/> NECK ABSCESS - IF REPEATED INFECTIONS <input type="checkbox"/> PAPILLOMA OF LARYNX: WITHOUT SIGNIFICANT AIRWAY OBSTRUCTION <input type="checkbox"/> PREAURICULAR SINUS- URGENT <input type="checkbox"/> REFLUX WITHOUT ESOPHAGEAL STRICTURE <input type="checkbox"/> REPAIR OF POSTERIOR LARYNGEAL CLEFT <input type="checkbox"/> SPEECH DELAY - VELOPHARYNGEAL INSUFFICIENCY <input type="checkbox"/> SNHL REQUIRING COCHLEAR IMPLANT AFTER MENINGITIS <input type="checkbox"/> SIALOLITHIASIS <input type="checkbox"/> SINO-NASAL MASS (BENIGN) <input type="checkbox"/> UNACCEPTABLE SCAR - NEW
3 (64 days)	P-CATS IV Criteria <ul style="list-style-type: none"> <input type="checkbox"/> ADENOIDECTOMY FOR NASAL OBSTRUCTION <input type="checkbox"/> BENIGN LESIONS (NOSTRIL, ORAL, LIP, FACIAL, TONGUE, EAR ETC.) <input type="checkbox"/> BENIGN TUMOUR OF SALIVARY GLAND <input type="checkbox"/> CHRONIC EPIPHORA-CONGENITAL INTRANASAL DEFORMITY <input type="checkbox"/> CHRONIC SINUSITIS WITH NASAL POLYPS <input type="checkbox"/> CHRONIC SUPPURATIVE OTITIS MEDIA/CHRONIC MASTOIDITIS WITH OR WITHOUT CHOLESTEATOMA <input type="checkbox"/> EPISTAXIS, RECURRENT <input type="checkbox"/> EUA (EARS) NON-URGENT <input type="checkbox"/> LARYNGOSCOPY/BRONCHOSCOPY FOR DIAGNOSIS OR SURVEILLANCE WITHOUT SIGNIFICANT AIRWAY OBSTRUCTION <input type="checkbox"/> MUCOCELE OF MAJOR SALIVARY GLAND <input type="checkbox"/> MYRINGOTOMY & TUBES FOR RECURRENT OTITIS MEDIA <input type="checkbox"/> MYRINGOTOMY & TUBES FOR OTITIS MEDIA WITH EFFUSION <input type="checkbox"/> NASAL DERMOID <input type="checkbox"/> NECK MASS - NO SUSPICION OF CANCER (INCLUDING THYROGLOSSAL, BRANCHIAL CLEFT ETC.) <input type="checkbox"/> OTHER CONGENITAL EAR DEFORMITIES (MAJOR) <input type="checkbox"/> OTHER CONGENITAL EAR DEFORMITIES (MINOR) <input type="checkbox"/> OTOPLASTY <input type="checkbox"/> SNHL REQUIRING COCHLEAR IMPLANT <input type="checkbox"/> TONSILLECTOMY WITH OR WITHOUT ADENOIDECTOMY – FOR OBSTRUCTIVE SYMPTOMS
4 (128 days)	P-CATS V Criteria <ul style="list-style-type: none"> <input type="checkbox"/> ANKYLOGLOSSIA <input type="checkbox"/> CHRONIC SINUSITIS WITHOUT NASAL POLYPS <input type="checkbox"/> CHOANAL ATRESIA: UNILATERAL <input type="checkbox"/> DEVIATED NASAL SEPTUM <input type="checkbox"/> HYPERTROPHIED TURBINATES CAUSING NASAL OBSTRUCTION <input type="checkbox"/> LYMPHATIC MALFORMATION: WITHOUT COMPROMISE <input type="checkbox"/> PERFORATION OF TYMPANIC MEMBRANE <input type="checkbox"/> RECONSTRUCTIVE MIDDLE EAR SURGERY <input type="checkbox"/> REHABILITATION OF CONDUCTIVE HEARING LOSS (BAHA) <input type="checkbox"/> STENOSIS OF THE EAR CANAL <input type="checkbox"/> SIALORRHEA CONTROL <input type="checkbox"/> TONSILLECTOMY WITH OR WITHOUT ADENOIDECTOMY – FOR RECURRENT INFECTIONS
5 (364 days)	P-CATS VI Criteria <ul style="list-style-type: none"> <input type="checkbox"/> COSMETIC NASAL DEFORMITY <input type="checkbox"/> PREAURICULAR SINUS- NON-URGENT <input type="checkbox"/> UNACCEPTABLE SCAR - OLD
Oncology	
1 (14 days)	P-CATS IIA CANCER Criteria: <ul style="list-style-type: none"> <input type="checkbox"/> SUSPECTED MALIGNANT NEOPLASM FOR DIAGNOSIS (HEAD & NECK) <input type="checkbox"/> Pediatric Diagnostic Surgical Oncology Cases
2 (21 days)	P-CATS IIB CANCER Criteria: <ul style="list-style-type: none"> <input type="checkbox"/> TREATMENT FOR MALIGNANT NEOPLASM (HEAD & NECK) <input type="checkbox"/> Pediatric patients diagnosed with highly aggressive malignancies
3 (28 days)	P-CATS III CANCER Criteria: N/A <ul style="list-style-type: none"> <input type="checkbox"/> (no specific diagnosis examples or criteria) <input type="checkbox"/> Cancer is not highly aggressive or indolent <input type="checkbox"/> Pediatric patients with suspected highly invasive Cancer
4 (42 days)	P-CATS IV CANCER Criteria: N/A <ul style="list-style-type: none"> <input type="checkbox"/> (no specific diagnosis examples or criteria) <input type="checkbox"/> Pediatric patients diagnosed or suspected to have indolent malignancies