PEDIATRIC SEDATION REQUEST + SCREENING FORM

DATE: __,__,____ ❑ Outpatient ❑ Inpatient Rm#______ Isolation? ❑ Y ❑ N

NOTE: *All sections **MUST** be filled out in order for us to schedule. If you have any questions with this sedation form, please contact the Sedation Coordinators at (608) 262-4402. Fax completed forms to (608) 266-6075, or tube to station 911.*

PATIENT INFORMATION

- Name: ____ MR#: ______________________
- DOB: ___/___/______ Weight: ________ kg Patient Phone#: (_____) ______-_________

____

Primary Diagnosis (Reason for procedure): ___________________ Secondary Diagnosis: _______________

Please CHECK BOX if patient has: ❑ Diabetes Mellitus ❑ Diabetes Insipldus ❑ Autism ❑ Metabolic d/o

Allergies: ____+ Egg/Soy Allergy: ❑ Yes ❑ No

PROCEDURE INFORMATION

- Procedure
- Priority: (needed within)

❑ 24 HRS • **FOR REQUESTS< 24 HRS, SEDATION MDIPNP MUST BE CONTACTED** @ 262-4402

❑ 1-3days ❑ 3-7days ❑ 1-2weeks ❑ 2-4weeks ❑ 4-6weeks ❑When convenient ❑ Other________

- <u>Exam Indications</u> (what is the reason for the procedure?): ❑ Routine Care/Follow-up

❑ Clinical Concern (please specify): ____

PATIENT PROBLEMS // CONDITIONS - NOTE: 1 or more boxes below <u>MUST</u> be checked:

❑ **AIRWAY ISSUES -**
The patient has a history of: Strider, Airway Obstruction, Difficulty controlling secretions, URI. The patient has: OSA, Micrognathia, CranioFacial Anomalies, Laryngomalacia, Neck Mass, Tracheotomy

❑ **PULMONARY PROBLEMS -**
The patient has a current history of: Respiratory distress, Wheezing or Oxygen Ventilator Requirement
The patient has: Chronic Lung Disease, Pneumonia, Tracheomalacia, Mediastinal Mass,

❑ **CARDIOVASCULAR PROBLEMS -**
The patient has a current history of: Congestive Heart Failure or Hemodynatnic Instability
The patient has: Congenital Heart Disease, Myocarditis, Cardiomyopathy or Dysrrythmia

❑ **NEUROLOGIC D1SOR0ERS -**
The patient has current history of: Altered Mental Status, Poorly Controlled Seizures, Enlarging HCM
The patient has: Hydrocephalous, VP shunt, Cerebral Palsy

❑ **GASTROINTESTINAL/METABOLIC PROBLEMS -**
The patient has a current history of: Bowel Obstruction, Vomiting, or GERO
The patient has: Obesity, Electrolyte Abnormalities

❑ **OTHER PROBLEMS -** Down Syndrome, Severe Anemia (Hct < 24), "Craniofacial" Syndrome, Fever

❑ **<u>NO</u> PROBLEMS LISTED ABOVI: -** The patient <u>does not</u> have any of conditions listed above

CONTACT INFORMATION

- Attending MD: ___________________ Phone#:_______________________ Pager #: _______________

Person completing form if different than ordering M.D. ______________________ Pager#: _______________

- Follow up Appt. Needed: ❑ Yes ❑ No Same/Different Day: ___________________________________
- Family time/day preferences: ____