

**PEDIATRIC PRE-SEDATION HISTORY & PHYSICAL**

## NOTE: Must be completed for patients under10 years old (or ≥ 10 if sedation required) before appointment will be booked.

Procedure: Diagnosis:

Current Medications:

DATE (dd/mm/yy) PATIENT

DOB (dd/mm/yy) PROV HC#

Vital Signs: HR RR SaO2 BP Ht. Wt. BMI Zscore

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Physical Exam | Airway/Neck N abN | Respiratory N abN | CVS N abN | Neuro N abN |
| Comment |  |  |  |  |

|  |  |
| --- | --- |
| **A. Medical History P**-Present/**A**-Absent | Describe |
| Allergies |  P A |  |
| Tracheostomy in situ |  P A |  |
| Recent fever/URI |  P A |  |
| Down Syndrome, Achondroplasia |  P A |  |
| Liver disease |  P A |  |
| Kidney disease, difficulty voiding or frequent voiding |  P A |  |
| Easy bruising or bleeding tendencies |  P A  |  |
| Diabetes or other endocrine disorder |  P A |  |
| Neurological abnormality, seizures, headaches, changes in vision, coordination, or level of consciousness |  P A |  |
| Family history of muscle disease/weakness Developmental delay, Autism, FAS, ADHD |  P A |  |
| Other diseases (e.g. sickle cell disease) |  P A |  |
| **B. Previous Surgery** |  P A |  |
| **C. Relevent Patient or Family History of anesthetic- related problems (e.g. malignant hyperthermia** |  P A |  |

|  |  |
| --- | --- |
| **D. Assessment of Sedation Risk Factors Y**-Yes/**N**-No | Describe |
| Snoring with sleep apnea or stridor |  Y N |  |
| Craniofacial malformation |  Y N |  |
| Limited cervical spine mobility |  Y N |  |
| Past history of difficult airway |  Y N |  |
| Past history of sedation failure |  Y N |  |
| Reactive airways disease/asthma (uncontrolled) |  Y N |  |
| Pneumonia or new-onset oxygen requirement |  Y N |  |
| Gastroesophageal reflux or vomiting (active) |  Y N |  |
| Complex cardiac disease |  Y N |  |
| Altered mental status (recent onset) |  Y N |  |
| Suspicion of mitochondrial or metabolic disorder |  Y N |  |
| Allergy to Egg or Soy |  Y N |  |

## If you have any questions, please call the Diagnostic Imaging Department at (204) 787-5780

Form Completed By:

 MD

SIGNATURE (Printed Name and Sign) AND CLASSIFICATION DATE Signed