

**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