



# Center of Procedural Excellence

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**WWW.CONNECTICUTCHILDRENS.ORG**

## Sedation Services Request Form (This form is a consult request for sedation services)

*Entire form must be completed for procedure with sedation to be scheduled.*

Today's Date \_\_\_\_\_

Patient Name \_\_\_\_\_ Patient DOB \_\_\_\_\_

Patient Diagnosis \_\_\_\_\_

Procedure or Test Requiring Sedation \_\_\_\_\_ Date and Time Requested \_\_\_\_\_

Requesting Provider (PRINT) \_\_\_\_\_ (SIGNATURE) \_\_\_\_\_ Requesting Provider Contact Number \_\_\_\_\_

Person Completing Form \_\_\_\_\_ Requesting Service Contact Number \_\_\_\_\_

Legal Guardian Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Guardian Home Phone Number \_\_\_\_\_ Guardian Cell Number \_\_\_\_\_

Interpretive Services Needed?  Yes *Language* \_\_\_\_\_

### To Be Completed by Requesting Provider MD or RN (Or attach recent history/physical)

#### Does the patient have a history of any of the following conditions?

- Prior problem with anesthesia or sedation?.....  Yes  No
- Facial or airway abnormalities?.....  Yes  No
- Obesity?.....  Yes  No
- Obstructive or sleep apnea?.....  Yes  No
- On CPAP, BIPAP or Oxygen?.....  Yes  No
- Chronic or active respiratory condition?.....  Yes  No
- Congenital Heart Disease?.....  Yes  No
- Swallowing difficulty?.....  Yes  No
- Autism, ADHD or severe development delay?.....  Yes  No
- Congenital or chromosomal syndrome?.....  Yes  No
- History of Bleeding Disorder?.....  Yes  No
- History of Muscle Weakness?.....  Yes  No

#### Other Medical Conditions? (Describe below)

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**This form is a working document and not a part of the medical record**

#### Office Use Only

RN  PA/APRN  Physician Review

Name \_\_\_\_\_ Date \_\_\_\_\_

Ok for sedation, schedule as planned

Need more info: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Refer to anesthesia: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Scheduled: \_\_\_\_\_

Informed:  **Requesting Service, Date/Time:** \_\_\_\_\_

Scheduler's Initials: \_\_\_\_\_