Connecticut Children's MEDICAL CENTER

Center of Procedural Excellence

860.837.6345 *phone* 860.545.9072 *fax* **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?		**Other Medical Conditions?** (Describe below)
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	

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: _____