

- ☐ University of Kentucky A.B. Chandler Hospital
- ☐ UK HealthCare Good Samaritan Hospital
- ☐ UK HealthCare Ambulatory Services
- ☐ UK Dental and Oral Health Clinics

## KENTUCKY CHILDREN'S HOSPITAL PEDIATRIC SEDATION REQUEST FORM

(Patient Label Here)

Phone 859-257-5337, Fax 859-323-2768

**\*\*Required** for procedural sedation to be scheduled:

1. **Entire form** must be completed and
2. Attach recent **history, physical and medication list** with completed form

Weekend or After Hours Weekdays  
(after 4 p.m.)  
**Emergency Sedation**  
Call OR desk @ 859-323-5631

### PATIENT DEMOGRAPHIC AND PROCEDURE INFORMATION

|                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                      |                           |                                                                                                                           |                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|---------------------------------------------------------------------------------------------------------------------------|----------------------------|
| Today's Date                                                                                                                                                                                                                                                                                      |  | Patient Last Name                                                                                                                                    |                           | First Name                                                                                                                |                            |
| Date of Birth                                                                                                                                                                                                                                                                                     |  | Patient MR#                                                                                                                                          |                           | Diagnosis                                                                                                                 |                            |
| Parent/Guardian Name                                                                                                                                                                                                                                                                              |  |                                                                                                                                                      | Procedure to be performed |                                                                                                                           |                            |
| Street Address                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                      | Phone #                   |                                                                                                                           |                            |
| City                                                                                                                                                                                                                                                                                              |  | State                                                                                                                                                |                           | Zip                                                                                                                       |                            |
|                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                      |                           |                                                                                                                           | Alternate Phone # or email |
| Date Procedure Needed?                                                                                                                                                                                                                                                                            |  | Today <input type="checkbox"/> ASAP (within 3 days) <input type="checkbox"/> First Available <input type="checkbox"/> Other <input type="checkbox"/> |                           |                                                                                                                           |                            |
| Will patient be inpatient or outpatient at time of procedure?                                                                                                                                                                                                                                     |  | Inpatient <input type="checkbox"/>                                                                                                                   |                           | Outpatient <input type="checkbox"/>                                                                                       |                            |
| Has child been sedated at KCH or UK Healthcare before?                                                                                                                                                                                                                                            |  | No <input type="checkbox"/> Yes <input type="checkbox"/>                                                                                             |                           | By whom? PICU Sedation Team <input type="checkbox"/> Anesthesia <input type="checkbox"/> Unknown <input type="checkbox"/> |                            |
| If deemed appropriate based on child's age and demeanor and the procedure, is it ok to evaluate child, or discuss with family, the child's ability to have procedure performed without sedation? (if left blank, assumption will be yes) YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                                                                                                                                      |                           |                                                                                                                           |                            |

### PATIENT MEDICAL HISTORY

|                                                                                                                     |                              |                                                                                                                              |  |                                                                        |                                                          |
|---------------------------------------------------------------------------------------------------------------------|------------------------------|------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|----------------------------------------------------------|
| Patient weight in KG                                                                                                | kg                           | Patient Medications:                                                                                                         |  |                                                                        |                                                          |
| Patient height in CM                                                                                                | cm                           |                                                                                                                              |  |                                                                        |                                                          |
| Patient Medication Allergies:                                                                                       |                              | Is patient allergic to egg or soy? YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown <input type="checkbox"/> |  |                                                                        |                                                          |
| <b>Does the Patient have any of the following conditions? (answer all questions, explain any yes answers below)</b> |                              |                                                                                                                              |  |                                                                        |                                                          |
| Problems with prior anesthesia or sedation?                                                                         | YES <input type="checkbox"/> | NO <input type="checkbox"/>                                                                                                  |  | GERD?                                                                  | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Airway abnormalities?                                                                                               | YES <input type="checkbox"/> | NO <input type="checkbox"/>                                                                                                  |  | Autism, ADHD, or severe developmental delay?                           | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Obstructive apnea?                                                                                                  | YES <input type="checkbox"/> | NO <input type="checkbox"/>                                                                                                  |  | Less than 6 month old and history of prematurity (<37 weeks at birth)? | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| On CPAP, BiPAP or oxygen?                                                                                           | YES <input type="checkbox"/> | NO <input type="checkbox"/>                                                                                                  |  | Congenital syndrome or chromosomal anomaly?                            | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Chronic or active respiratory condition (asthma, BPD, pneumonia, etc)?                                              | YES <input type="checkbox"/> | NO <input type="checkbox"/>                                                                                                  |  | Other medical condition?                                               | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Heart Disease (congenital or otherwise)?                                                                            | YES <input type="checkbox"/> | NO <input type="checkbox"/>                                                                                                  |  | Difficult IV access?                                                   | YES <input type="checkbox"/> NO <input type="checkbox"/> |

Comment for all "YES" answers above:

### REQUESTING PROVIDER INFORMATION

|                              |
|------------------------------|
| Person Completing Form       |
| Requesting Service Contact # |
| Requesting Physician         |
| Physician Contact # or Pager |

### OFFICE USE ONLY

|                                                                                                                 |      |
|-----------------------------------------------------------------------------------------------------------------|------|
| Reviewed by:                                                                                                    | Date |
| Sedation by: RN <input type="checkbox"/> PICU Team <input type="checkbox"/> Anesthesia <input type="checkbox"/> |      |
| Scheduled for:                                                                                                  |      |
| Who informed:                                                                                                   | Date |