



**Procedural Sedation History & Physical**  
 (Revised Nov 2014)

Patient Name:		Age:	Allergies: Include food, drug, latex <input type="checkbox"/> NKDA		
Appointment Date and Time:		Weight:                      kg	Pre-Procedure Diagnosis:		
Procedure:					
Relevant History to explain the need for the procedure:					
Other Relevant Medical Conditions: <input type="checkbox"/> History of bleeding problems, Asthma, or BPD. If checked, provide details <input type="checkbox"/> History of severe heart or lung disease. If checked, provide details					
Previous Sedation History:					
Psychological Evaluation: <input type="checkbox"/> Normal for age If not normal for age, list concerns that explain the need for sedation or condition that may interfere with administration of sedative					
Recent Infectious Disease Exposure and Date: <input type="checkbox"/> None				Pregnancy Status: <input type="checkbox"/> N/A	
<b>Current Medications</b> <small>(Include OTC and/or illicit drugs)</small>			<b>Indicate ASA Physical Status Classification:</b> <input type="checkbox"/> Class 1: A normally healthy patient <input type="checkbox"/> Class 2: A patient with mild systemic disease <input type="checkbox"/> Class 3: A patient with severe systemic disease that limits activity but is not incapacitating		
Drug	Dose	Route			Time
If on <u>anti-seizure</u> medications: <input type="checkbox"/> Give the dose as scheduled <input type="checkbox"/> OK to hold the dose until after the test is done					
Relevant Physical Exam:	Normal (√)	Describe Abnormal Findings			
HEENT					
Heart: Rhythm, Murmurs, etc.					
Lungs: Rales, Rhonchi					
Other PE Findings:					
Assessment:		<b>Sedation Request</b>			
		Note that chloral hydrate is no longer available. All physicians may order: <input checked="" type="checkbox"/> Sedation per sedation physician <small>Refer to Physician's Guidelines for Ordering Pediatric Sedation</small>			
I have informed the patient/patient's responsible party of the: a) nature of the treatment/procedure recommended, b) risks/benefits of the sedation medication(s) involved in such treatment/procedure, c) alternative forms of treatment including non-treatment available, d) anticipated results of the treatment.					
Physician's Signature:			Date:		

**Fax a copy to 983-6722 and provide the family with a copy to be brought with them.**

I agree with the above findings and find no changes except where noted	
Sedation Physician's Signature:	Date: