KAPI'OLANI MEDICAL CENTER FOR WOMEN & CHILDREN
An affiliate of Hawai'i Pacific Health

Procedural Sedation History & Physical
(Revised Nov 2014)

Name: ____________________________  Age: _______  kg  Allergies: Include food, drug, latex  [ ] NKDA

Appointment  Procedure:  Pre-Procedure  Diagnosis:
Date and Time:

Relevant History to explain the need for the procedure:

Other Relevant Medical Conditions:  [ ] History of bleeding problems, Asthma, or BPD. If checked, provide details
[ ] History of severe heart or lung disease. If checked, provide details

Previous Sedation History:

Psychological Evaluation: [ ] 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:  [ ] None  [ ] N/A

Pregnancy Status:  [ ] N/A

Current Medications
(Include OTC and/or illicit drugs)

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
<th>Route</th>
<th>Time</th>
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Indicate ASA Physical Status Classification:

- [ ] Class 1: A normally healthy patient
- [ ] Class 2: A patient with mild systemic disease
- [ ] Class 3: A patient with severe systemic disease that limits activity but is not incapacitating

If on anti-seizure medications: [ ] Give the dose as scheduled
[ ] OK to hold the dose until after the test is done

Relevant Physical Exam:

HEENT
Heart: Rhythm, Murmurs, etc.
Lungs: Rales, Rhonchi

Other PE Findings:

Assessment:

Sedation Request

Note that chloral hydrate is no longer available.

All physicians may order:

☒ Sedation per sedation physician

Refer to Physician's Guidelines for Ordering Pediatric Sedation

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: ________________