HAWAIʻI PACIFIC HEALTH | KAPIʻOLANI MEDICAL CENTER FOR WOMEN & CHILDREN

Diagnostic Imaging Department
Sedation Request Form

Patient: ______________________________________ DOB: ____

In order to schedule the appropriate sedation for your patient, please consider the following guidelines and check the preferred sedation provider. If you are unsure which provider is appropriate for your patient, please call the Sedation Coordinator at 983-8516. It is helpful if you provide a recent H&P.

- ☐ **EMP – IV Sedation**: No airway compromise, absence of severe cardiopulmonary disease (e.g., well-controlled asthma, isolated seizure disorder)
  *Please order "Sedation per sedation provider" on Pre-Sedation Evaluation form.

- ☐ **Pediatric Anesthesiologist – IV Sedation**: Potentially difficult airway, severe cardiopulmonary disease (i.e., obstructive sleep apnea, pulmonary hypertension), long sedation time, difficult IV start or inability to cooperate with awake IV placement. Age under 6 months.
  *Please order "Sedation per sedation provider" on Pre-Sedation Evaluation form.

Once we have this information we will schedule the appointment.

Please sign this sheet and fax it to 808-983-8710. Thank you.

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Print MD's Name MD's Signature Date

Diagnostic Imaging Department use only

OR Scheduler's name: ________________________ Appointment confirmed date/time: ____________________
ORSOS case #: ___________________ Appointment date and time: _____________________________________
M.D. office notified of appointment date: ____

	1st Choice	2nd Choice	3rd Choice	
Date:				
Sedation time:				
Scan time:				