UVa HSC Sedation Screening Information Sheet
(If “sedation required” is marked on the ordering form, please complete this form and fax with the request to 434-243-6999 in addition to any recent clinical information)

Patient name: ________________________ Weight: ________ LB   KG (Circle one)

Please schedule this test:

☐ Emergent (within one week)
   PLEASE EXPLAIN: (required)___________________

☐ Urgent (within 2-3 weeks)
   PLEASE EXPLAIN: (required)___________________

☐ Routine
   or suggested date: __________________

Co-existing conditions: (Please mark all that apply)

☐ Airway concerns:
   ☐ Obstructive sleep apnea/Severe snoring
   ☐ Apnea monitor in use
   ☐ Mediastinal chest mass
   ☐ Tracheomalacia/laryngomalacia
   ☐ Tracheostomy
   ☐ Craniofacial syndromes/anomalies:_________________
   ☐ Poor control of oral secretions
   ☐ Morbid obesity

☐ Cardiac disease:
   ☐ Cyanotic congenital heart disease
   ☐ Non-cyanotic congenital heart disease
   ☐ Myocardial dysfunction

☐ Pulmonary disease:
   ☐ Moderate to Severe Pulmonary hypertension
   ☐ Chronic lung disease
   ☐ Cystic fibrosis
   ☐ Oxygen requirement

☐ Other:
   ☐ Frequent movements while sleeping
   ☐ Bowel obstruction
   ☐ Egg allergy - severe
   ☐ Liver disease
   ☐ Neuromuscular disorder
   ☐ Moderate to severe scoliosis
   ☐ Ex-preemie under 1 year old
   ☐ Genetic syndrome: ____________________________
   ☐ Severe behavior disorder
   ☐ Problem with previous sedation/anesthesia

☐ NONE OF THE ABOVE

Signature: _____________________________________

12/07 em:vt