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