

Sedation Request Form

Kentucky Children's Hospital Sedation Service

Scheduling Phone 859-257-5337, Fax 859-323-1940

E-mail ljmart3@email.uky.edu

Please fill in and return to Leslie Martin, sedation scheduler.

Today's date* _____

Patient Name* Diagnosis*

DOB* MR#

Weight (KG)* Height (CM)* Medications:

Drug Allergies* Type of Med Rxn

Is patient allergic to eggs or soy?* Type of Egg/Soy Rxn

Parent/Guardian Name* Parent Contact Number*

Does the patient have any of the following conditions? (Comment on all checked answers)*

problem with prior anesthesia or sedation poorly controlled seizures

chronic respiratory condition (asthma, BPD, etc.) airway abnormalities

congenital heart disease obstructive sleep apnea

GERD On O2?

congenital syndrome Specify: prematurity (<36 wks at birth) and is now <6 mo old

Comments:

Person completing form* Contact phone number*

Type and Location of Procedure* Estimated length of procedure

Proposed date and time for procedure Requesting Physician*

Requesting Service* Pager or contact #

Attention: Leslie Martin

For Office Use Only		BMI
		BMI %ile
Date family contacted	Comments	