Email Form

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Form can be returned by clicking 'Email Form' to open outlook.

Sedation Request Form
WRNMMC-Bethesda Pediatric Sedation Unit

Scheduling: (301) 400-1594, Front Desk: (301)400-2030

Please complete and return this form via email. ALL FIELDS REQUIRED. Thank you.

dha.bethesda.wrnmmc.mbx.pedsedation@mail.mil

Today's date:	DOD ID:
Patient Name:	DOB (month/day/year):
FMP/sponsor's last 4:	AGE:
Parent/guardian name:	#2
Contact Numbers: #1	

Type of procedure(s):

Have all CHCS test orders been entered (imaging and/or labs): ◯ Yes ◯ No

NOTE: If patient has metal braces, this will impact brain and head MRI images.

Diagnosis: Weight (kg):

Medications:

Allergies: Drugs, Latex, Iodine, Food _____ Type of reaction:

Allergic to eggs or soy: ◯ Yes ◯ No Type of egg/soy reaction:

Does the patient have any of the following conditions? Please comment on all 'Yes' answers.

Prior difficulty with anesthesia/sedation: ◯ Yes ◯ No

Congenital syndrome: ◯ Yes ◯ No

Poorly controlled seizures: ◯ Yes ◯ No

Airway abnormalities: ◯ Yes ◯ No

Obstructive sleep apnea: ◯ Yes ◯ No

Congenital heart disease: ◯ Yes ◯ No

Chronic respiratory condition (asthma, BPD, tracheomalacia, etc.): ◯ Yes ◯ No

Prematurity (< 36 weeks at birth and now < 6 months old): ◯ Yes ◯ No

Comments:

****For MRI's - Parents MUST provide documentation to sedation for ALL implants to obtain clearance for scans.****

Requesting provider:	Requesting service:
Email:	Pager or contact #:

For Office Use Only

Date: Procedures: Time: Cancelled: Rescheduled:

Date family contacted:	Comments: