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Pediatric Day Surgery Pre-Operative Assessment

THIS PAGE IS TO BE COMPLETED BY PATIENT'S PARENTS

Patient's Name: _____ Date of Birth: _____

Address: _____ Phone: _____

Planned Dental Treatment: _____

1. **Has your child been seen or treated in a hospital?** Yes / No
   If yes, when?

_____

2. **Any complications?** Yes / No
   If yes, please describe:

_____

3. **Has your child ever had an anesthetic?** Yes / No

4. **Did your child have any problems with an anesthetic?** Yes / No
   If yes, please describe:

_____

5. **Has anyone in your family had a problem with an anesthetic?** Yes / No
   If yes, when?

_____

6. **Does your child have any allergies?** Yes / No
   If yes, please describe:

_____

7. **Was an allergy due to:**

a) medicine	Yes / No	if yes, please describe:	_____
b) food	Yes / No	if yes, please describe:	_____
c) other	Yes / No	if yes, please describe:	_____

8. **If your child has an allergy, do they have:**

a) rash or hives	Yes / No
b) trouble breathing	Yes / No
b) high fever	Yes / No

9. **Has your child had a cold or cough in the past week?** Yes / No if yes, please describe: _____

10. **has your child been exposed to any infectious diseases in the past month? (e.g. chicken pox, measles, etc)** Yes / No
If yes, please list: _____

10. **Does your child have:**

a) breathing problems	Yes / No	if yes, please describe:	_____
b) heart problems	Yes / No	if yes, please describe:	_____
c) seizure disorder	Yes / No	if yes, please describe:	_____
d) developmental delay	Yes / No	if yes, please describe:	_____
c) diabetes	Yes / No	if yes, please describe:	_____
c) other	Yes / No	if yes, please describe:	_____

11. **Is your child receiving any medication now?** Yes / No if yes, please list: _____

12. **does your child or anyone in the family have a bleeding problem?** Yes / No
   If yes, please describe:

_____

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THIS PAGE IS TO BE COMPLETED BY A PHYSICIAN

Height: _____ **Weight: _____**

Temperature: _____ **Pulse: _____**

Respirations: _____ **Blood Pressure: _____**

Hemoglobin: _____ **Sickle Cell Test: _____**

Physical Exam:_____
_____
_____
_____
_____
_____

Nose and Throat: _____
_____
_____
_____
_____
_____

Heart: _____
_____
_____
_____
_____

GUIDELINES FOR PRE-OPERATIVE TESTING IN CHILDREN

A. Hemoglobin

1. Infants < 1 year
2. Patients at risk for hemoglobinopathy (i.e. affro caribbeans, (i.e. affro caribbeans, hemophiliacs, positve family history)
3. Patients with history of chronic disease (e.g. congenital heart, rheumatoid arthritis, cystic fibrosia, chronic renal failure, mallgnancy, chemotherapy)
4. Surgery associated with potential significant blood loss
   - tonsillectomy and adenoidectomy
   - cleft palate
   - craniofacial repair
   - burn grafting
   - major orthopedic procedures: scoliosis repair, osteotomy
   - liver biopsy
   - cardiac procedures
5. History and physical exam suggestive of anemia
   - chronic blood loss
   - dietary insufficiencie (e.g significant dental)
   - pregnancy
   - fatigue, pallor and tachycardia

A hemoglobin done within 3 months of the time of surgery is adequate, provided there has been no intercurrent change in medical status.

B. Sickle Cell Prep

All patients of Afro-Carribbean descent

C. Other Tests

The need for pre-operative urinalysis, electrolyte determinations and chest x-rays is guided by the history and physical exam

Lungs:_____
_____
_____

History of Present Illness: _____
_____
_____

Diagnosis: _____
_____
_____

Proposed Procedure: _____
_____
_____

Date: _____

Physician's Signature: _____

Physician's Name: _____
(Please Print)