Connecticut Children's MEDICAL CENTER

Center of Procedural Excellence

860.837.6345 *phone* 860.545.9072 *fax* **WWW.CONNECTICUTCHILDRENS.ORG**

Sedation Services Request Form *(This form is a consult request for sedation services)*

Entire form must be completed for procedure with sedation to be scheduled.

Today's Date _____

Patient Name _____ Patient DOB _____

Patient Diagnosis _____

Procedure or Test Requiring Sedation _____ Date and Time Requested _____

Requesting Provider (PRINT) _____ (SIGNATURE) _____ Requesting Provider Contact Number _____

Person Completing Form _____ Requesting Service Contact Number _____

Legal Guardian Name _____ Relation to Patient _____

Guardian Home Phone Number _____ Guardian Cell Number _____

Interpretive Services Needed? ☐ Yes *Language* _____

To Be Completed by Requesting Provider MD or RN (Or attach recent history/physical)

Does the patient have a history of any of the following conditions?		**Other Medical Conditions?** (Describe below)
Prior problem with anesthesia or sedation?	☐ Yes ☐ No	
Facial or airway abnormalities?	☐ Yes ☐ No	
Obesity?	☐ Yes ☐ No	
Obstructive or sleep apnea?	☐ Yes ☐ No	
On CPAP, BIPAP or Oxygen?	☐ Yes ☐ No	
Chronic or active respiratory condition?	☐ Yes ☐ No	
Congenital Heart Disease?	☐ Yes ☐ No	
Swallowing difficulty?	☐ Yes ☐ No	
Autism, ADHD or severe development delay?	☐ Yes ☐ No	
Congenital or chromosomal syndrome?	☐ Yes ☐ No	
History of Bleeding Disorder?	☐ Yes ☐ No	
History of Muscle Weakness?	☐ Yes ☐ No	

This form is a working document and not a part of the medical record

Office Use Only

☐ RN ☐ PA/APRN ☐ Physician Review

Name _____ Date _____

☐ Ok for sedation, schedule as planned

☐ Need more info: _____

☐ Refer to anesthesia: _____

Scheduled: _____

Informed: ☐ **Requesting Service,** *Date/Time:* _____

Scheduler's Initials: _____

Center of Procedural Excellence CoPE – Connecticut Children's Medical Center

Vaccine Administration Form

Patient Name: _____

Patient DOB: _____

1. Please have the ordering primary care physician sign the attestation that they have discussed the risk and benefits with the family for the ordered vaccine(s) and that the child has no contraindications to vaccine administration.
2. Please check the box(es) next the vaccine(s) being ordered

Attestation:

I have discussed the risks/benefits of the vaccines ordered below with the patient/caregiver. The patient has no medical contraindications to receiving these vaccines.

Physician Name:_____

Signature:_____

Date:_____

List of available vaccines through CCMC Pharmacy (as of 10/24)

CHECK	VACCINE BRAND	VACCINE GENERIC	
□	ActHib	Hib	
□	Boostrix	Tdap	
□	Enerix-B	Hepatitis B	
□	Flulaval (Quad-Flu)	Influenza 0.5ml	(seasonal)
□	Gardasil 9	HPV 9	
□	Havrix	Hepatitis A	
□	Infanrix	DTaP	
□	IPOL	IPV (Inactivated Polio)	
□	MMR II	MMR	
□	Menveo	MCV4 (Meningitis A/C/Y/W-135)	
□	Pediarix	DTaP/IPV/Hep B	
□	Pentacel	DTaP/IPV/Hib	
□	Vaxelis	DTAP/IPV/HIP/Hep B	
□	Prevnar 13	PCV 13	
□	Rotateq	Rotavirus	
□	Tenivac	Td	
□	Varivax	Varicella	
□	Bexsero	Meningococcal B	
□	Beyfortus	RSV Nirsevimad-alip (>24mo)	
□	Covid	Covid Vaccine	