CENTER FOR PEDIATRIC IMAGING
Pediatric Sedation Request Form

Please print clearly

PATIENT'S NAME:____ DATE_____/______/______

ADDRESS:____ PHONE: Day-___________________________

D.O.B.________________ WEIGHT__________ Cell-___________________________

Approval to leave message Yes ☐ No ☐

INTERPRETER NEEDED OR SPECIAL DEVICE Yes ☐ No ☐

INSURANCE PROVIDER____ NUMBER_______________________________

CPT Code______________ **Diagnosis Code**______________ ***STATE CUSTODY*** **YES** ☐ **CONSENTING GUARDIAN:** ____________________________

RADIOLOGY:

☐ MRI ☐CT ☐VCUG ☐Ultrasound guided biopsy

☐ Brain ☐ Neck ☐ Chest Other__________________

☐ Abdomen ☐ Pelvis ☐ Spine: _C _T _L _S ☐ Extremities: **Site/Side** _______________

PROCEDURE:

☐ ECHO ☐ BAER (hearing) ☐LP ☐Bone Marrow ☐ PICC ☐ Other________________________

DIAGNOSIS/ INDICATION____

PERTINENT MEDICAL HISTORY____

ALLERGIES:____

CURRENT MEDICATIONS:____

PAST SEDATION HISTORY/ COMPLICATIONS:____

SEDATION RISK ASSESSMENT: RISK ASSESSMENT NEGATIVE ☐

PREMATURITY☐**NO** ☐ **YES: WKS GESTATION**________ **Any child under 1 month of age or ex-premature infant less than 55 weeks gestational age must be admitted for observation following sedation. Child will require admission.**

AIRWAY/CRANIOFACIAL ABNL________________________________ METABOLIC/GENETIC SYN____________________

CARDIAC DEFECT__________________☐ **IV CARDIAC FILTER REQUIRED** RENAL FUNCTION_____________

CRANIAL SHUNT/TYPE/SETTING____

SIGNATURE OF ATTENDING PHYSICIAN/NP:____

PRINTED NAME OF REQUESTING MD/ NP:____

PLEASE FAX OR MAIL COMPLETED FORMS FOR:

MRI- FAX- (401) 444-7699
(401) 444-2404

CT, VCUG- FAX- 444-7699
PHONE- 444-2404

PROCEDURES- FAX 444-8816
PHONE- 444-6091

Rev 1/12