Appendix 11:

Pre-procedural checklist

To be completed and signed by sedation practitioner

Name:		Date of birth:	
Age:		Weight:	
Responsible doctor:		Sedation practitioner:	
Procedure: Elective/Emergency/Urgent		Name of accompanying adult:	
Has the patient completed a medical questionnaire? Yes / No			
Has the patient been fully evaluated? Yes / No		Has the patient been physically examined and evaluated? Yes / No	
Sedation contraindication checklist			
Past sedation history Details:	Yes / No	Previous sedation satisfactory Details:	Yes / No
Airway problems Details:	Yes / No	Previous failed sedation Reason:	Yes / No
Raised intracranial pressure Details:	Yes / No	Previous complications of sedation Details:	Yes / No
Sleep apnoea	Yes / No	Depressed level of consciousness	Yes / No
Respiratory failure	Yes / No	Serious illness Details:	Yes / No
Fasting time checklist			
Fasted for solids (including milk)		From: (minimum 6 hours)	
Fasted for clear juice/water		From: (minimum 2 hours)	
Significant underlying conditions (see medical questionnaire)			
Renal dysfunction	Yes / No	Cardiac dysfunction	Yes / No
Hepatic dysfunction	Yes / No	Gastro-oesophageal reflux	Yes / No
Respiratory dysfunction	Yes / No	Known allergies/drug reactions	Yes / No
Chronic medication If yes, have they been taken today?	Yes / No Yes / No	Specify chronic medication:	

Premedication and monitoring	
Premedication prescribed and by whom:	Drug: Dose: Time: Drug: Dose: Time:
Premedication administered: Yes / No	Name of person who administered premedication:
Name of sedation practitioner: Qualification:	Name of qualified attendant:

Equipment checklist (tick if present)					
Pulse oximeter		NIBP		ECG	
Airway equipment		Oxygen		Drugs	
Resuscitation equipment		Temperature probe		Circulatory support equipment	

Signature of sedation practitioner:……Date:……

Name of sedation practitioner (block letters): ……

Qualification:……