Appendix 11: Preprocedural checklist

(To be completed and signed by sedation practitioner)

Child's name:	Date of birth: Premature birth? Yes / No
Age: Weight:	In hospital/Outside hospital
Responsible doctor:	Procedure: Elective/Emergency/Urgent
Sedation practitioner evaluating child:	Was a medical questionnaire completed? Yes / No
Has the child been fully evaluated? Yes / No Date:	ASA Status:
Name of parent/caregiver accompanying child:	Name of parent/carer responsible for aftercare:
Sedation contraindication checklist	
Past sedation history? Yes / No Details:	Previous sedation airway problems? Yes / No Details:
Previous sedation satisfactory? Yes / No / NA Details:	Sleep apnoea? Yes / No Reason:
Previous sedation failed? Yes / No / NA Details:	Any syndromic features? Yes / No Details:
Previous sedation complications? Yes / No / NA Details:	Serious illness? Yes / No Details:
Fasting time checklist	
Fasted for solids (including milk)?	From: (minimum 6 hours)
Fasted for breast milk?	From: (minimum 4 hours)
Fasted for clear juice/water?	From: (minimum 2 hours)
Other significant underlying conditions (see medical questionnaire)	
Respiratory dysfunction? Yes / No	Hepatic dysfunction? Yes / No
Cardiac dysfunction? Yes / No	Gastro-oesophageal reflux? Yes / No
Known allergies/drug reactions Yes / No	Renal dysfunction? Yes / No
Chronic medication? Yes / No If yes, have they been taken today? 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: ……