Procedures Under Sedation Clinic

Additional referral information form:

To facilitate timely and appropriate triage of your referral, we request additional information about your patient, including a detailed summary of their previous procedure experience and the reason they require sedation for this request.

Please attach this form in addition to the RCH Specialist Clinics referral form and fax to (03) 9345 5034. Alternatively, email to screferrals@rch.org.au

PATIENT DETAILS:

Name:
DOB:
Hospital Number:

CONTACT DETAILS:

PARENT / GUARDIAN	Name:
HOME ADDRESS	Address:
CONTACT DETAILS	Email: Phone:
INTERPRETER REQUIRED	□ YES □ NO LANGUAGE:

REASON FOR REFERRAL:

TEST REQUESTED:	Please include Pathology Slips for all tests requested.
PREVIOUS VENEPUNCTURE ATTEMPTS:	□ YES □ NO Details:
PREVIOUS SEDATION ATTEMPTS:	□ YES □ NO Details:

REASON FOR SEDATION:	Provide Further Details:
❍ Increased anxiety associated with regular blood tests / injections ❍ Previous traumatic and/or unsuccessful attempts ❍ Neurodevelopmental Disorder(s) predisposing to procedure-related trauma ❍ Other	

MEDICAL HISTORY:

RELEVANT MEDICAL HISTORY	
WEIGHT	**KGs**
HEART RATE	
BLOOD PRESSURE	
ALLERGIES	□ YES □ NO Details:
CURRENT MEDICATIONS	□ YES □ NO Details:

Completed By _____ Date: _____