SPECTRUM HEALTH
Helen DeVos children's hospital

History/Physical
REQUEST FOR HISTORY/PHYSICAL - OUTPATIENT, PEDIATRIC SEDATION AND SURGERY TEAMS

REQUEST FOR HISTORY/PHYSICAL

Dr. _____ (fax # _____) has ordered a procedure with sedation to be performed by the Helen DeVos Children's Hospital Pediatric Sedation Service or the Pediatric Surgery Department. In order to comply with The Joint Commission requirements, a history and physical must be completed within 30 days of the procedure. For Pediatric Sedation/Procedure Team procedures, fax the completed form to **(616) 267-1261**. For Pediatric Surgery procedures, fax the completed form to (616) 643-9290. These should be received at least 2 business days prior to the scheduled procedure. The form needs to be completed by a Physician, Physician Assistant, or Nurse Practitioner and needs to minimally address heart and lung sounds.

Patient name _____ DOB _____

Procedure scheduled _____ Date _____ Time _____

Diagnosis _____

Indication for procedure _____

HISTORY

Past medical history/Review of systems (**include copies of pertinent letters from referral physicians/specialists)**

_____

_____

_____

_____

_____

_____

Past surgical history/hospitalizations _____

Past patient/family history with sedation/anesthesia (**describe any adverse reactions**) _____

_____

Medications _____

Allergies/Reactions: ☐ Egg ☐ Soy ☐ Latex Describe _____

☐ Medication and/or food (list) _____

Recent labs and/or x-rays _____

Recent weight _____ kg Date _____ Recent height _____ cm Date _____

Age/Developmental level (**include any special needs/concerns)** _____

_____

_____

PHYSICAL EXAMINATION

SYSTEM	NO ABNORMALITIES	IF ABNORMALITIES, NOTE SIGNIFICANT FINDINGS
General	☐	
HEENT	☐	
Pulmonary	☐	
Cardiovascular	☐	
Abdomen	☐	
Genitourinary	☐	
CNS	☐	
Musculoskeletal	☐	
Other _____	☐	

TIME _____ **DATE** _____ Provider signature _____ Title _____

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