Is there anything else you would like to tell the preoperative care team about your child?

_____

_____

_____

Would you like to have a pre-admission visit to the hospital? ☐ Yes ☐ No

This would be opportunity for you and your child to be shown around the theatre admission unit. Alternatively there is a virtual tour available online.

Completed by _____ Telephone Home _____

Relationship to child _____ Mobile _____

Date ___/___/___ Email_____

Please ensure your child has had their height & weight measured before leaving

Thank you for completing this form

This information will be used by your child's nurse, anaesthetist, doctor and allied health staff and will become a part of their confidential hospital file.

If you have any queries about this form, please contact the Preop care Coordinator Tel: 0114 3058133

We may need to contact you by telephone or email to ask further questions.

Visit the Sheffield Children's Hospital website for more information
There is lots of information you may find useful to prepare your child for their general anaesthetic.
You may find it useful to take a photo of the link below, or follow the QR code.

Theatre Admissions Unit Virtual Tour:
www.sheffieldchildrens.nhs.uk/patients-and-parents/theatre-admissions-unit/

BMI Interpretation		
<2nd Centile	Underweight	☐
9-90thCentile	Healthy	☐
91-98th centile	Overweight	☐
98-99.6th centile	Obese	☐
> 99.6th Centile	Severe obesity	☐

Weight ..... Kg
Height..... cm
BMI .....

☐ Investigations Details _____

☐ Safe guarding Details _____

☐ Co-operation Details _____

☐ Other Details _____

14632

AFFIX PATIENT LABEL

SCH PATIENT NUMBER .....

SURNAME .....

GIVEN NAME(S) .....

DATE OF BIRTH .....

SEX .....

NHS NUMBER.....

Pre-Anaesthetic Health Questionnaire

Sheffield Children's NHS
NHS Foundation Trust

This form will help us prepare your child for a general anaesthetic.

PLEASE COMPLETE AND RETURN TO THE RECEPTIONIST PRIOR TO LEAVING OUTPATIENTS.

Please answer ALL questions as accurately as possible and tick ✔ where necessary

Do you need an interpreter? ☐ No ☐ Yes **If yes**, specify which language _____

What is the planned procedure under general anaesthetic? _____

_____

Is your child waiting for any other procedures under general anaesthetic at Sheffield Children's Hospital?

☐ No ☐ Yes **If yes**, please provide details / expected dates_____

_____

Has your child been admitted to hospital in the last 12 months?
If yes, which hospital and why?

_____

_____

Please give details of the most recent or important admissions _____

_____

Does your child have a chronic illness, special needs, disability or any of the following? ☐ No ☐ Yes

☐ Breathing problems	☐ Joint disorder	☐ Learning difficulties
☐ Sleep apnoea (snores/pauses breathing)	☐ Metabolic condition	☐ Behavioural disorders (Autism / ADHD)
☐ Premature birth (less than 37 wks)	☐ Kidney disorder	☐ Visual impairment
☐ Eczema	☐ Liver disorder	☐ Hearing loss
☐ Diabetes (type 1 or 2)	☐ Heart problems	☐ Fits or Epilepsy
☐ Cystic Fibrosis	☐ Reflux (GORD)	☐ Cerebral Palsy
☐ Recurrent chest infections	☐ Constipation	☐ Anxiety or depression
☐ Downs syndrome	☐ Muscle disorder	☐ Syndrome_____

Other conditions and further details

_____

_____

_____

SCH Pre-anaesthetic Health Questionnaire
Version 11 Oct 2019

Filed Tab-Theatre documentation, Subtab -Pre-op

SCH607

Does your child suffer with asthma or wheeze? ☐ No ☐ Yes

How often are they woken by their breathing during the night?

☐ Never ☐ Occasionally ☐ Frequently ☐ Many times ☐ Unable to sleep

How limited are they in their activities due to their breathing?

☐ Not at all ☐ Slightly ☐ Moderately ☐ Extremely ☐ Totally

How many puffs of their reliever inhaler (like Salbutamol/Ventolin) have they used each day?

☐ None ☐ 1-2 ☐ 3-4 ☐ 5-8 ☐ > 8 puffs most days

Has their asthma therapy had to be increased in the last few weeks?

☐ No ☐ Yes

Have they had a course of steroids in the last 3 months?

☐ No ☐ Yes

Have they had a hospital admission for their asthma?

☐ No ☐ Yes (ED/Ward/HDU/PICU) When? _____

Does your child have any allergies or reactions to medications (NSAIDS eg Ibuprofen with asthma), latex, foods, colourings, chlorhexidine, tapes etc? ☐ No ☐ Yes

If yes, please provide details _____

_____

Please provide details of your child's medication including inhalers, oral contraceptive, or herbal remedies

Name	Dose	Frequency

PLEASE BRING ALL MEDICINES, INHALERS INCLUDING SPACER

Does your child have / use any of the following?

☐ Feeding tubes (NG/PEG/PEJ)	☐ Vagal nerve stimulator	☐ VP Shunt
☐ Cochlear implant/Hearing aid	☐ Wheel Chair dependence	☐ Breathing support (NIPV/CPAP
☐ Baclofen pump	☐ Pacemaker / defibrillator	☐ Home Oxygen
☐ Tracheostomy	☐ Bladder catheter	☐ Insulin Pump
☐ Home suction	☐ Incontinence products	☐ Central line / Port

If ✔ please give details (model, size, settings) _____

_____

Is there any history of the following in your child or family?

Bleeding / Clotting disorder	☐ Child	☐ Family
Sickle Cell (Disease or Trait) / Thalassemia	☐ Child	☐ Family
Creutzfeldt-Jakob disease (CJD)	☐ Child	☐ Family
Blood transfusion concerns eg. Jehovah Witness	☐ Child	☐ Family
Past blood Transfusions	☐ Child	
MRSA/CPE	☐ Child	☐ Family

If **yes**, please provide details _____

_____

Has your child had an anaesthetic previously? ☐ No ☐ Yes **If so where, when and what for?**

_____

_____

_____

_____

Do you know of any problems with anaesthetics in the past? (eg. Airway/breathing problem, fever, malignant hyperthermia, suxamethonium apnoea, sickness, agitation, pain)

Your child ☐ No ☐ Yes

Your family ☐ No ☐ Yes

If **yes**, please provide details _____

_____

_____

Does your child cope well with procedures and tests (e.g. dentist, blood test?)

☐ Yes ☐ No

If **NO** does anything help them co-operate? (Distraction / Sedation etc.) _____

_____

_____

Has your child used any of the following resources before?

☐ Dietician Details _____

☐ Occupational therapy Details _____

☐ Physiotherapy Details _____

☐ Social work Details _____

☐ Psychology Details _____

☐ CAMHS keyworker Details _____

☐ Weight Management Details _____

Does anyone in your family smoke?

☐ No ☐ Yes

Details_____

Are your child's vaccinations up to date?

☐ Yes ☐ No ☐ Not sure

VACCINATIONS SHOULD BE AVOIDED 48 HOURS BEFORE AN ANAESTHETIC.

AFFIX PATIENT LABEL

SCH PATIENT NUMBER .....

SURNAME .....

GIVEN NAME(S) .....

DATE OF BIRTH .....

SEX .....

NHS NUMBER .....