G2 Anesthesia Services Inc
SUPERIOR SAFETY, SUPERIOR SLEEP

10907 Oak Harbor Drive Louisville, KY 40299 (833) 336-8482. FAX 800-478-1368

Anesthesia Patient Health Questionnaire (Pediatric)

Initial Here_______

Child's Name ________________________________ Weight _______ lb. Nickname ____________________

Your Name ______________________________________ Address___________________________________

Your Relationship to Child __________________________ ___________________________________

Your Home Phone ________________________________ ___________________________________

Pediatrician or Clinic ______________________________

Work/Cell Phone ________________________________ Pediatrician Phone _____________

Child's Medical History

1. Medication or Food Allergies:
   - ☐ None Known
   - ☐ Yes If Yes, to what? __________

   ____

2. Medications:____

____

____

3. Previous Surgery or Anesthesia
   - ☐ None
   - ☐ Yes (If yes, please write them): ____

   ____

   ____

4. Previous Hospitalizations:
   - ☐ None
   - ☐ Yes (If yes, please write them below)

   At what age?____

   What hospital?____

   Reason for Hospitalization:____

   Procedure(s):____

   ____

   ____

5. Any problems with anesthesia in the past?
   - ☐ None
   - ☐ Yes If yes, what happened?_______________

   ____

   ____

Continue on to next page until page 4

6. Is there a family history of anesthetic problems?

- ☐None
- ☐Yes If yes, what happened? ____

____

7. Was your child premature?

- ☐No
- ☐Yes
  - If yes, how early?____________________
  - What was the birth weight? _________
  - Birth place: __________________________
  - Was your child in a neonatal intensive care unit?
    - ☐No
    - ☐Yes If yes, how long? ___
    - Was your child on a ventilator
      - ☐No
      - ☐Yes If yes, how long?___________________

8. Has your child been on an apnea monitor?

- ☐No
- ☐Yes If yes, is he/she on one now?
  - ☐No If no, when was it discontinued? __________________________
  - ☐Yes

9. Has your child ever had chicken pox?

- ☐No
- ☐Yes

Chicken pox vaccine?

- ☐No
- ☐Yes

Has your child been exposed to chicken pox in the past 3 weeks?

- ☐No
- ☐Yes

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Anesthesia Patient Health Questionnaire (Pediatric) Initial Here_______

10.

Medical Problems (check if yes and explain)

- ☐ Cough or runny nose in past month ______________________________
- ☐ Fever in the past month ______________________________
- ☐ Sore throat or hoarseness in past month ______________________________
- ☐ Difficulty breathing ______________________________
- ☐ Croup (barking cough) or stridor ______________________________
- ☐ Asthma or wheezing ______________________________
- ☐ Pneumonia ______________________________
- ☐ Acid Reflux or Heartburn ______________________________
- ☐ Aspiration or choking episodes ______________________________
- ☐ Swallowing or Eating Problems ______________________________
- ☐ Heart Murmurs or Irregular Heart Beat ______________________________
- ☐ Other Heart Problems ______________________________
- ☐ Nausea, vomiting or diarrhea in past month ______________________________
- ☐ Recent weight loss ______________________________
- ☐ Kidney Problems ______________________________
- ☐ Liver Problems ______________________________
- ☐ Hepatitis ______________________________
- ☐ Previous Blood Transfusions; when was the last transfusion?______________________________
- ☐ Bleeding Problems ______________________________
- ☐ Anemia or low blood count ______________________________
- ☐ Sickle Cell Disease ______________________________
- ☐ Seizures ______________________________
- ☐ Thyroid Problems ______________________________
- ☐ Muscle or Bone Problems ______________________________
- ☐ Cerebral Palsy ______________________________
- ☐ Developmental Delay ______________________________
- ☐ Snoring or sleep apnea ______________________________
- ☐ HIV / AIDS ______________________________

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11. Is your child able to keep up playing with children of similar age?

- ☐ Yes
- ☐ No If no, please explain ____

12. Are there smokers in the house?

- ☐ No
- ☐ Yes

Is there anything else we should know about your child? ________________________________

____

____

Signature of Parent / Guardian ________________________________Date _________

END OF QUESTIONNAIRE

Continue on to next page until page 4

CONSENT FOR ANESTHESIA SERVICES

I,____________________________ , acknowledge that my doctor has explained to me that I or my child will have an operation, diagnostic, or treatment procedure— medical or dental related. My doctor has explained the risks of the procedure, advised me of alternative treatments, and told me about the expected outcome and what could happen if my condition remains untreated. I also understand that anesthesia services are needed so that my doctor can perform the procedure.

It has been explained to me that all forms of anesthesia involve some risks and no guarantees or promises can be made concerning the results of my procedure or treatment. Although rare, unexpected severe complications with anesthesia can occur and include the remote possibility of infection, bleeding, drug reactions, blood clots, loss of sensation, loss of limb function, paralysis, stroke, brain damage, heart attack or death. I understand that these risks apply to all forms of anesthesia and that additional or specific risks have been identified below as they may apply to a specific type of anesthesia. I understand that the type(s) of anesthesia service checked below will be used for my procedure and that the anesthetic technique to be used is determined by many factors including my physical condition, the type of procedure my doctor is to do, my doctor's preference, and my own preference. It has been explained to me that sometimes an anesthesia technique which involves the use of local anesthetics, with or without sedation, may not succeed completely and therefore another technique may have to be used including general anesthesia.

☐ Deep IV Sedation and General Anesthesia (IV= Intravenous)	Expected Result	Total unconscious state, possible placement of a tube into the nose mouth and windpipe
	Technique	Drug injected into the bloodstream, breathed into the lungs, or administered by other routes
	Risks	Mouth or throat pain, hoarseness, injury to mouth or teeth, awareness under anesthesia, injury to blood vessels, aspiration, pneumonia

☐ Moderate/Conscious IV Sedation (IV= Intravenous)	Expected Result	Total or partial amnesia, reduced anxiety and pain, Intermittent periods of brief unconsciousness Able to follow commands
	Technique	Drug injected into the bloodstream, breathed into the lungs, or administered by other routes
	Risks	An unconscious state, depressed breathing, injury to blood vessels Partial or total memory of the procedure Advancement to General Anesthesia with associated risks.

☐ I understand that my anesthesia may be advanced to DEEP IV SEDATION and GENERAL ANESTHESIA if Moderate IV Sedation is not effective as determined by my doctor or anesthetist.

☐ I prefer that my anesthesia NOT BE advanced to Deep IV Sedation and General Anesthesia and stopping the procedure IF the procedure being performed safely permits me to be awakened.

Signature________________________________ Date_______________________

Guardian Signature________________________________

G2 Anesthesia HIPAA AUTHORIZATION___________________

I, ____________________, give permission to G2 Anesthesia to use my protected health information, and/or disclose the my protected health information to:

- Anesthesia Billing Company, Inc.
- List your insurance company or companies:
  ____
  ____
- Your Primary Care provider(s) and/or skilled Nursing Facility Providers.

Information to be disclosed:

- Medical Records
- Dental Records
- Treatment Records
- Diagnostic Records
- Other: (If applicable)____

This protected health information is being used or disclosed for the following purposes:

- Provider fee reimbursement. (ie. Third party insurance billing)
- Medical or dental consultations related to your treatment and continuity of care.

This authorization expires after one year.

If any person or entity listed above receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits.

You may inspect or copy the protected health information to be used or disclosed under this authorization. For protected health information created as part of a clinical trial, your right to access is suspended until the clinical trial is completed.

Finally, you may revoke this authorization in writing at any time by sending written notification to G2 Anesthesia. See our web site for our office address. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

____ __________________
Signature of Participant or Personal Representative Date

____
Printed Name of Participant or Personal Representative

____
Description of Personal Representative's Authority

PRE-ANESTHESIA INSTRUCTIONS-- Before coming to the Dentist office:

1. Notify G2 Anesthesia if you have any sudden changes to your health as soon as become aware. This is especially true for even mild colds or flu-like symptoms.
2. Take your regular medications with sips of water as instructed by your Anesthetist.
3. Arrange for transportation for your return home by a responsible friend.
4. Nothing to eat or drink for at least 8 hours before your appointment, except for your regular medications.
5. Urinary incontinence may occur so bring a change of clothing and/or wear an appropriate sized pad or diaper.

POST ANESTHESIA INSTRUCTIONS-- Leaving after your sedation:

1. During your surgery, you will be given an anesthetic to make you comfortable and free of pain. This will be administered either by a fully-trained Certified Registered Nurse Anesthetist (CRNA), dental anesthesiologist (DMD), or physician (M.D.) anesthesiologist.
2. You are required to have a responsible person transport you from the doctor's office after surgery. Someone must stay with you for the next 24 to 48 hours.
3. You may be unaware of the effects of the anesthetic for 24 to 48 hours, even though you may think you feel fine.
4. During this time, you should not engage in any activity that could be harmful to yourself or others, such as driving, smoking in bed, or using power equipment.
5. You should exercise caution and seek assistance when engaging in activities such as walking, climbing stairs, or going to the bathroom. A responsible person should be readily available to assist you with your needs.
6. For some patients undergoing prolonged general anesthesia (more than 3 hours), know that post anesthesia recovery will continue after you arrive home. You will likely need a wheelchair getting to your car and may rely on someone able to provide assistance with strength and balance when you arrive home. We will not discharge you from care unless we are sure that you have recovered sufficiently from anesthesia and your caretaker is appropriate to assist you.
7. You should eat only very light, easily digested foods and liquids for the next 24 hours.

My signature below indicates that I have fully read and understand these post anesthesia instruction and that my anesthesia provider has fully explained any questions that I have regarding my responsibilities related to receiving anesthesia.

____
Patient Name

______________________ Date:____________ Time:_________
Patient Signature