3 Hole 1/4 4 1/4 c-to-c

Children's
of Alabama®

1600 7th Avenue South
Birmingham, Alabama 35233
Telephone (205) 638-9596

Children's of Alabama One Day Surgery

Welcomes You

Name _____

Race _____
(for Sickle Cell Determination)

Medical Record # _____

Date of
Surgery _____

Doctor_____

Procedure _____

Pre-Op Blood Product _____

Consults:_____

Isolation precautions: _____

History & Physical: _____

Permit order: _____

Radiology Orders:

❑ _____

Check Labs Completed:

❑ CBC
❑ Fluid Balance Panel
❑ Type & Screen / Crossmatch
❑ Other _____

Labs DOS:

❑ CBC
❑ FBP
❑ Urine Pregnancy Test
❑ Other _____

3 Hole 1/4 4 1/4 c-to-c

Physician Checklist

_____ Reservation Scheduled

_____ Pre-Certification

_____ Completed History & Physical
signed, dated and timed

_____ Informed Consent
signed, dated and timed

_____ Required Labs

_____ Pre-Operative Information Sheet
Completed and given to family

_____ Directions/Map given to family

_____ Anesthesia Pre-Screening Visit

_____ Race (for Sickle Cell status)

Children's of Alabama®

3 Hole 1/4 4 1/4 c-to-c

ONE DAY SURGERY • PRE-OP INFORMATION SHEET

Parents / Guardians Please Read Important Surgery Information

ARRIVAL INFORMATION

Please arrive at Children's Hospital

_____ _____ _____ at _____ as scheduled by your child's physician.

Month Day Year Time

If you have any questions as to your arrival time please contact your physician's office.

Thank you for choosing our One Day Surgery for your child's upcoming surgery or procedure. Our goal is to provide the best possible care for you and your child. In order to accomplish this goal, we have developed these helpful guidelines for you to review before surgery. The One Day Surgery staff is eager to serve you. If you have any questions, please call us at (205) 638-9596.

Please do not give ANYTHING to eat after midnight. From midnight until 4:00 a.m. your child may have only clear liquids to drink, these may include water, apple juice, tea, sprite, Pedialyte, white grape juice, Gatorade or jello, unless otherwise instructed by your physician's office.

The Day Before Surgery:

1. Call your physician if your child develops fever, cold, rash or has been exposed to any contagious illnesses (especially chicken pox).
   Your physician may wish to postpone your child's outpatient procedure or refer you to your regular pediatrician for a letter of clearance prior to having surgery.
2. Your physician will discuss pre-op instructions and arrival time with you as well. If you have any questions regarding your special instructions and/or arrival time please contact your physician.
3. **It is important that your child's stomach be empty before undergoing anesthesia for surgery. No solid food is allowed after midnight on the night before your child's procedure, which also includes formula, milk products, orange juice, breast milk, cereal, gum or hard candy.**
4. Patients should bathe the night before surgery and brush teeth if appropriate.

The Day of Surgery:

1. Please bring your parking ticket to One Day Surgery when you arrive. The staff will validate your ticket at any of our desks. Parents receive free parking. Visitors receive a discounted rate.
2. Patients under 19 must be accompanied by the custodial parent or a legal guardian. One parent or guardian **must** remain on the unit at all times.
3. **All** patients must be accompanied by a responsible adult. Patients are not permitted to drive after anesthesia and surgery.
4. Due to the size constraints, only two visitor (parents, legal guardian) at a time are allowed to stay with the patient in their room pre and post-op.

Checklist for the Day of Surgery:

Please feel free to bring the following items with you to One Day Surgery (these items may enhance your child's surgery experience):

___ Comfort items (i.e. pacifier, blanket, pillow, stuffed animal, PJ's, house shoes)
___ Special items (i.e. sippy cups, special bottles, breast milk pump, feeders, diapers & wipes)
___ Place a towel in your car (some children experience nausea and vomiting after surgery and during the car ride home)
___ Please dress your child in comfortable, loose fitting clothing.
___ Please bring your child's One Day Surgery Booklet if your physician has given it to you.

Please remove the following items prior to arrival at the hospital (**these items are not allowed in the operating room**):

___ Jewelry, including earrings and any body piercings
___ Metal hair clips, braids etc.
___ Nail polish on fingers or toes
___ Contacts (Please bring your contact case and supplies)
___ Eye glasses (Glasses will be removed prior to entering operating room)

Children's
of Alabama®

Healthcare as amazing as their potential

HOW TO FIND US?

Your child's surgery/procedure will be at the (please check one):

_____ Children's of Alabama - Lowder Building
205-638-9597

_____ Benjamin Russell Hospital for Children
205-638-9596

McWane and Lowder Buildings:

Parking: Parking is available in Children's 7th Avenue Parking Deck, located across from the entrance of the McWane building on 7th Avenue South. Use the crosswalk on level 2 of the parking deck for direct entry to the hospital's second floor. After exiting the crosswalk, follow the hallway to the right through the hospital and into the Lowder Building. Enter the second glass-front waiting area immediately to your left and register at the One Day Surgery desk. You may also enter through the 7th Avenue Entrance. After entering the main lobby, turn right at the information desk and continue through the lobby into the adjacent Lowder Building. Take elevator to the 2nd floor. Enter the glass front waiting area immediately to your right and register at the One Day Surgery desk. *Parents and Family Clergy park free, all other visitors receive parking at a discounted rate. Please bring your Parking Deck Ticket with you so that it can be validated.*

Benjamin Russell Hospital for Children:

Parking: Parking is available in Children's 5th Avenue Parking Deck, located across from the entrance to the Benjamin Russell building on 5th Avenue South. Enter the parking deck on the 16th Street South side. Use the crosswalk on level 2 which will take you to the 2nd floor of the hospital. As you enter the hospital, you will use the public elevators to the right of the information desk and go to the 3rd floor. As you exit the elevator hallway, you will be at the Preop registration desk. *Parents and Family Clergy park free, all other visitors receive parking at a discounted rate. Please bring your Parking Deck Ticket with you so that it can be validated.*

Children's
of Alabama®

TRAVEL DIRECTIONS TO CHILDREN'S OF ALABAMA

From I-65N to Children's of Alabama

7th Avenue Parking Deck (McWane and Lowder Buildings)

Travel I-65 North and take the University Boulevard/8th Avenue South (exit # 259). Travel approximately one block to 13th Street South. Turn left on 13th Street. Travel four blocks and turn right on 4th Avenue South (one way street). Travel approximately five blocks to 18th Street South and turn right. Travel three blocks and turn right on 7th Avenue South. Travel approximately two blocks. The 7th Avenue Parking Deck is located on the left. The McWane and Lowder buildings are on the right, located across the street from the parking deck.

I-65S to Children's of Alabama

7th Avenue Parking Deck (McWane and Lowder Buildings)

Travel I-65 South and take the 4th Avenue South (exit #259B). Travel approximately five blocks and turn right onto 18th Street South. Travel three blocks and turn right on 7th Avenue South. Travel approximately two blocks. The 7th Avenue Parking Deck is located on the left. The McWane and Lowder buildings are on the right, located across the street from the parking deck.

From Hwy 280/31 North

Elton B. Stephens Expressway/Red Mountain Expressway to Children's of Alabama 7th Avenue Parking Deck (McWane and Lowder Buildings)

Travel North on Hwy 280/31 North – Elton B. Stephens Expressway/Red Mountain Expressway exit onto 8th Avenue South/University Blvd. At traffic light turn right onto 8th Avenue South/University Boulevard. Travel seven blocks (approx. ¾ mile) and turn right on 18th Street South. Travel 1 block and turn left on 7th Avenue South. Travel approximately two blocks. The 7th Avenue Parking Deck is located on the left. The McWane and Lowder buildings are on the right, located across the street from the parking deck.

Hwy 280/31 South

Elton B. Stephens Expressway/Red Mountain Expressway to Children's of Alabama 7th Avenue Parking Deck (McWane and Lowder Buildings)

Travel I-20/59 South on Hwy 280/31 - Elton B. Stephens Expressway/Red Mountain Expressway. Travel approximately 2 miles and take the 3rd/4th Avenue South exit. At end of ramp turn right and take the first left on to Third Avenue South (one way street). Travel approximately 8 bocks to 18th Street South and turn left. Travel four blocks and turn right on 7th Avenue South. Travel approximately two blocks. The 7th Avenue Parking Deck is located on the left. The McWane and Lowder buildings are on the right, located across the street from the parking deck.

From I-65North to Children's of Alabama

5th Avenue Parking Deck (Benjamin Russell Hospital for Children Building and Emergency Department)

Travel I-65 North and take the University Boulevard/8th Avenue South (exit #259). Travel approximately one block to 13th Street South. Turn left on 13th Street. Travel four blocks and turn right on 4th Avenue South (one way street). Travel approximately three blocks to 16th Street South and turn right. Children's 5th Avenue Parking Deck is located on the left. The Benjamin Russell Hospital for Children building is directly across 5th Avenue from the parking deck. Children's Emergency Department is located at the corner of 16th Street South and 5th Avenue South in the Benjamin Russell Hospital for Children Building.

From I-65 South to Children's of Alabama

5th Avenue Parking Deck (Benjamin Russell Hospital for Children Building and Emergency Department)

Travel I-65 South taking the 4th Avenue South (exit #259B). Travel approximately four blocks on 4th Avenue South and turn right on 16th Street South. Children's 5th Avenue Parking Deck I located on the left. The Benjamin Russell Hospital for Children building is directly across 5th Avenue from the parking deck. Children's Emergency Department is located at the corner of 16th Street South and 5th Avenue South in the Benjamin Russell Hospital for Children Building.

From Hwy 280/31 North

Elton B. Stephens Expressway/Red Mountain Expressway to Children's of Alabama 5th Avenue Parking Deck (Benjamin Russell Hospital for Children Building and Emergency Department)

Travel North on Hwy 280/31 North – Elton B. Stephens Expressway/Red Mountain Expressway and exit onto 8th Avenue South/University Boulevard. At traffic light at end of ramp turn right onto 8th Avenue South/ University Boulevard. Travel seven blocks (approx. ¾ mile) and turn right onto 18th Street South. Travel three blocks and turn left onto 5th Avenue South. Travel approximately two blocks and turn right on 16th Street South. The Children's 5th Avenue Parking Deck entrance is located on the right. The Benjamin Russell Hospital for Children building is directly across 5th Avenue from the parking deck. Children's Emergency Department is located at the corner of 16th Street South and 5th Avenue South in the Benjamin Russell Hospital for Children Building.

From Hwy 280/31 South

Elton B. Stephens Expressway/Red Mountain Expressway to Children's of Alabama 5th Avenue Parking Deck (Benjamin Russell Hospital for Children and Emergency Department)

Travel I-20/59 to Hwy 280/31 South - Elton B. Stephens Expressway/Red Mountain Expressway (exit 126A). Travel approximately 2 miles and take the 3rd/4th Avenue South exit. At end of ramp turn right and take the first left onto 3rd Avenue South (one way street). Travel approximately 10 blocks to 16th Street South. Turn left on 16th Street South. The Children's 5th Avenue Parking Deck entrance is located on the left. The Benjamin Russell Hospital for Children building is directly across 5th Avenue from the parking deck. Children's Emergency Department is located at the corner of 16th Street South and 5th Avenue South in the Benjamin Russell Hospital for Children Building.

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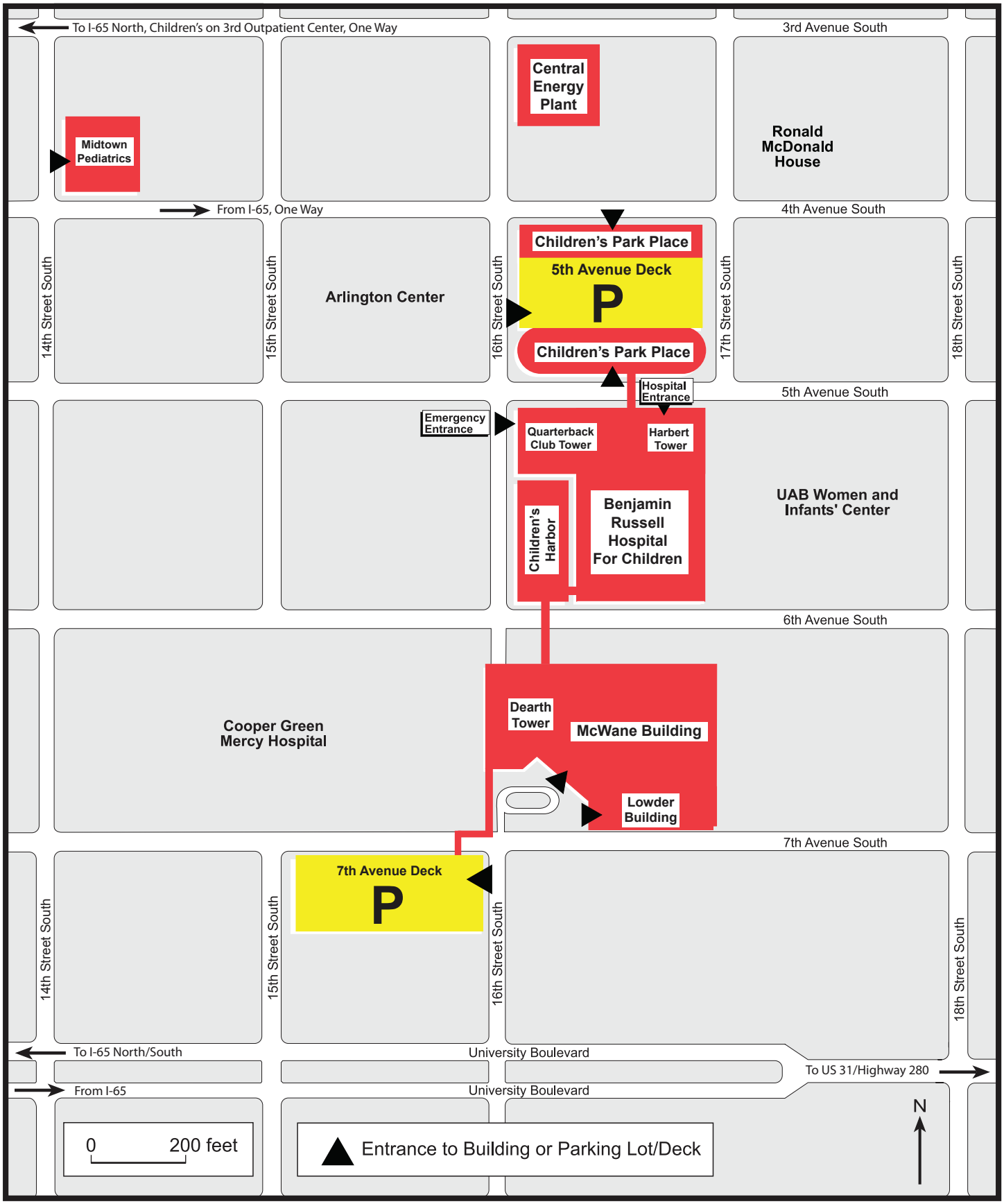

ANESTHESIA PRE-ADMIT SCREENING SERVICE (APASS)

Preparing Your Child for Anesthesia

An evaluation by Anesthesia Pre-Admit Screening Service (APASS) before surgery can help to avoid or predict potential medical, anesthesia, or surgical complications. APASS can also help provide information about the entire surgical and anesthesia process. APASS evaluations are available to all patients scheduled for surgery and their families. There is no charge for the APASS evaluation.

WAYS TO OBTAIN AN APASS EVALUATION

1. **Complete the 4 page APASS questionnaire in your surgeon's office.**
   - If you filled out the APASS questionnaire in your surgeon's office, you do not need to call APASS for a phone interview or complete the online questionnaire.

2. **NO COMPUTER ACCESS**
   - Call to schedule an APASS clinic appointment or to request a phone interview.
   - APASS PHONE: 205-638-6235

3. **COMPUTER ACCESS**
   - Go to: www.childrensal.org
   - Search Word: APASS
   - Select: Anesthesia Pre-Admit Screening Service (APASS)
   - Click: Online Patient Questionnaire
   - Complete the patient questionnaire, click SUBMIT.
   - Your questionnaire will automatically be sent to APASS.
   - IF any further information is needed to screen your child before anesthesia is given for surgery, APASS will contact you.

Please feel free to call APASS 205-638-6235 for more information or to answer anesthesia-related questions. If you have questions about the surgery, please contact the surgeon's office.

APASS CONTACT INFORMATION

Children's of Alabama
1600 7th Avenue South
(APASS, 2nd Floor Lowder Building)
Birmingham, AL 35233

Phone: 205-638-6235 Fax: 205-638-5242 Email: apass@childrensal.org

Webpage: www.childrensal.org (search word: apass)

APASS Hours:
Monday-Friday
9 am to 4:30 pm
(Alternate phone interview hours available upon request.)

DT0004

Children's
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1600 7th Avenue South
Birmingham, AL 35233

Patient Label

ANESTHESIA PRE-ADMIT SCREENING SERVICE (APASS)

PRE- ANESTHESIA PATIENT QUESTIONNAIRE

Patient's FULL LEGAL Name (first, middle & last name)	**Patient's Date of Birth**	**Patient's Nickname (if applicable)**
Procedure(s)	**Date of Procedure**	**Surgeon/Ordering Provider(s)**

Mother's Name	Father's Name
Mother's Home Number ( )	Father's Home Number ( )
Mother's Cell Number ( )	Father's Cell Number ( )
Mother's Work Number ( )	Father's Work Number ( )
Mother's Other Number ( )	Father's Other Number ( )

If the patient's legal guardian is different than the patient's mother/father, please list.	Patient's LEGAL GUARDIAN Name(s)	Legal Guardian's Relationship to Patient
If the patient is in (DHR) Department of Human Resources custody, please provide DHR case worker contact info.	Name of DHR Case Worker DHR County:	DHR Case Worker Contact Number(s) Office ( ) Cell ( )

(Please complete if your child has EVER seen a specialty physician/provider.)

SPECIALTY	SPECIALTY PROVIDER'S NAME	SPECIALTY	SPECIALTY PROVIDER'S NAME
Cardiology		Neurology	
Endocrinology		Pulmonary	
Hematology/Oncology		Other Specialty	

Patient's Pediatrician or Primary Care Provider (PCP)	Pediatrician or PCP's Office Number ( )	Pediatrician or PCP's City & State

MEDICATION HISTORY □The PATIENT DOES NOT TAKE daily or as needed home MEDICATIONS, Inhalers/aerosols, vitamins or non-traditional/herbal supplements.

PATIENT'S MEDICATIONS _____
_____

Are there any cultural or religious beliefs that we need to know about to take care of your child? (ex: NO blood products)	□ NO □ YES-Please explain

Date Form Was Completed	Person Completing APASS Form	Relationship to Patient

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1600 7th Avenue South
Birmingham, AL 35233

Patient Label

APASS PRE- ANESTHESIA PATIENT QUESTIONNAIRE

Patient's Name:
Patient's DOB:

ALLERGY STATUS

TYPE OF PATIENT ALLERGY	MEDICATION OR SUBSTANCE THAT CAUSED THE PATIENT'S ALLERGIC REACTION AND REACTION (if applicable)	TYPE OF PATIENT ALLERGY	MEDICATION OR SUBSTANCE THAT CAUSED THE PATIENT'S ALLERGIC REACTION AND REACTION (if applicable)
LATEX ALLERGY □ NO □ YES		**FOOD ALLERGY** □ NO □ YES	
DRUG ALLERGY □ NO □ YES		**OTHER ALLERGY** □ NO □ YES	

FAMILY HISTORY (BIOLOGICAL MOTHER AND FATHER'S FAMILY)

FAMILY HISTORY OF PROBLEMS WITH ANESTHESIA (EX: MALIGNANT HYPERTHERMIA, Pseudocholinesterase Deficiency, etc.) □ NO □ YES-Please explain the family members relationship to the patient and reaction with anesthesia:	**FAMILY HISTORY OF MUSCLE DISORDERS** (EX: MUSCULAR DYSTROPHY, Myopathy, Central Core Disease, Multiminicore Disease, etc.) □ NO □ YES-Please explain the family members relationship to the patient and type of muscle disorder:
FAMILY HISTORY OF BLEEDING DISORDERS (EX: HEMOPHILIA, Von Willebrand Disease, Factor V Leiden, etc.) □ NO □ YES-Please explain the family members relationship to the patient and type of bleeding disorder:	**FAMILY HISTORY OF SICKLE CELL DISEASE/TRAIT OR THALASSEMIA** □ NO □ YES-Please explain the family members relationship to the patient and type of sickle cell disease/trait or thalassemia:

SURGICAL HISTORY

□The PATIENT HAS NEVER HAD SURGERY OR ANESTHESIA in the past.

TYPE OF SURGERY/ ANESTHESIA PROCEDURE	HOSPITAL	YEAR OR AGE
_____	_____	_____
_____	_____	_____
_____	_____	_____

HAS THE PATIENT EVER HAD A REACTION TO ANESTHESIA?

(EX: MALIGNANT HYPERTHERMIA, Pseudocholinesterase Deficiency, reactions to anesthesia medications, trouble placing the breathing tube, irregular heart rhythm/beat, severe nausea/vomiting, trouble breathing, slow to wake up, etc.)

□ NO

□ YES-Please explain:_____

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1600 7th Avenue South
Birmingham, AL 35233

Patient Label

APASS PRE- ANESTHESIA PATIENT QUESTIONNAIRE

Patient's Name:
Patient's DOB:

BIRTH HISTORY

Was the patient born early? □ NO (BORN FULL TERM) □ YES (BORN EARLY)	**(GESTATIONAL AGE) The patient was born at how many weeks or months?**	**How many days, weeks or months was the patient in the hospital at birth?**
BIRTH HOSPITAL	**BIRTH WEIGHT**	**WAS THE PATIENT A TWIN, TRIPLET OR MULTIPLE?** □ NO □ YES-Please explain.
BIRTH COMPLICATIONS □ APNEA □ BREATHING PROBLEMS □VENTILATOR	**BIRTH COMP (CONTINUED)** □ BLOOD TRANSFUSION □ HEART MURMUR □ JAUNDICE	**PLEASE LIST OTHER BIRTH COMPLICATIONS.** _____ _____

RECENT HISTORY

Has the patient been sick with a cold or virus in the last 7 days?	□ NO □ YES-Please explain Diagnosed with: Date diagnosed:
Has the patient had bronchitis, croup, pneumonia, flu or mononucleosis in the last 6 weeks?	□ NO □ YES-Please explain. Diagnosed with: Date diagnosed:
Has the patient had to take steroids in the last 2 months? (EX: Prednisone, Prednisolone, Orapred, etc.)	□ NO □ YES-Please explain Diagnosed with: Length of time on steroids: Date of last steroid dose:
Has the patient been seen in an Emergency Department (ED) or been admitted to a hospital in the last 3 months?	□ NO □ YES-Please explain. Diagnosed with: Date see in the ED? If admitted, dates the patient was in the hospital?
Does the patient have any problems opening their mouth or moving their head/neck?	□ NO □ YES-Please explain
Does the patient have any loose/broken/capped teeth or wear braces/permanent retainers?	□ NO □ YES-Please explain
Does the patient wear glasses or contact lenses?	□ NO □ YES-Please explain
Does the patient have piercings other than the ears?	□ NO □ YES-Please explain
Has the patient received a blood transfusion/product within the last 3 months?	□ NO □ YES-Please explain. Date of blood transfusion: Reason for blood transfusion:
Does the patient use tobacco products, alcohol or addictive/recreational drugs?	□ NO □ YES-Please explain
If the patient is FEMALE, has she ever had a menstrual cycle (period)?	□ NO □ YES Date of last cycle:

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Birmingham, AL 35233

Patient Label

APASS PRE- ANESTHESIA PATIENT QUESTIONNAIRE

Patient's Name:
Patient's DOB:

MEDICAL HISTORY

PATIENT HISTORY	PATIENT HISTORY
GENETIC DISORDERS (SYNDROMES), DEVELOPMENTAL DELAYS , PSYCHIATRIC DISORDERS (EX: Muscular dystrophy, myasthenia gravis, multiple sclerosis, down syndrome, pierre robin, autism, spina bifida, cerebral palsy, depression, anxiety, OCD, etc.) □ NO □ YES-Please explain	**NEUROLOGICAL DISORDERS** (EX: seizures, stroke, ventriculoperitoneal shunt, hydrocephalus, vagal nerve stimulator, etc.) □ NO □ YES-Please explain
LUNG DISORDERS (EX: asthma/reactive airway disease, wheezing, cystic fibrosis, CPAP/BiPAP, bronchopulmonary dysplasia, home ventilator, sleep apnea, home oxygen, apnea monitor □ NO □ YES-Please explain	**MUSCULOSKELETAL DISORDERS** (EX: bone fracture, scoliosis, torticollis, paralysis, spasticity, hypotonia, cervical spine injury, etc.) □ NO □ YES-Please explain
HEART CONDITION/DISEASE OR BLOOD PRESSURE ISSUES (EX: heart surgery, structural heart condition, murmur, irregular heart rhythm, pacemaker, high/low blood pressure, etc.) □ NO □ YES-Please explain	**KIDNEY DISORDERS** (EX: kidney reflux/disease, dialysis, etc.) □ NO □ YES-Please explain
GASTROINTESTIONAL/LIVER DISORDERS (acid reflux, ulcerative colitis, crohn's disease, aspiration, gastrostomy, failure to thrive, hepatitis, cirrhosis, etc.) □ NO □ YES-Please explain	**ENDOCRINE DISORDERS** (EX: diabetes, hypo/hyperthyroidism, graves disease, etc.) □ NO □ YES-Please explain
ABNORMAL AIRWAY ISSUES (EX: Tracheostomy, stridor, floppy airway, small mouth opening, etc.) □ NO □ YES-Please explain	**BLOOD DISORDERS OR CANCER** (EX: Stem cell transplant, cancer, leukemia, sickle cell disease/trait, thalassemia, von willebrand disease, hemophilia, anemia, etc.) □ NO □ YES-Please explain
CONTAGIOUS ILLNESSES (EX: tuberculosis, MRSA, HIV/AIDS, etc.) □ NO □ YES-Please explain	**ANY OTHER DISORDERS** (EX: organ transplant, cochlear implant, blood transfusion history, immune deficiency, etc.) □ NO □ YES-Please explain
Does the patient have any implantable metallic devices? (Please circle if applicable.)	Cochlear Implant, Implantable Programmable Shunts, Dental Braces/Implants/Permanent Retainers or Hardware, Surgically Implanted Metallic Devices/Hardware
Is there anything else that we should know about the patient in order to take care of them on the date of the procedure? □ NO □ YES-Please explain:	

DT0030

MEDICATION/TREATMENT ORDER
One Day Surgery

Form#

Children's of Alabama
1600 7th Avenue South
Birmingham, AL 35233

A«PatientNumberText»

«AdmitDate» «PatientNumber»
«PatientName»
MR#: «MedicalRecordNumber» LOC: «Location» «Room» «Bed»
«AttendingDoctorName» DOB: «BirthDate»

STANDARD ADMINISTRATION TIMES

Daily 0800
Nightly 2100
Twice a day 0800-2000
Three times a day 0800-1400-2000
Every 12 hours 0800-2000
Four times a day 0800-1200-1600-2000
Every 3 hours 0000-0300-0600-0900-1200-1500-1800-2100
Every 4 hours 0000-0400-0800-1200-1600-2000
Every 6 hours 0200-0800-1400-2000
Every 8 hours 0000-0800-1600

Date:____ / ____ / _____ Time:_____

MEASUREMENTS:

Admit Wt: _____ Kg ☐Measured **Ht:_____ Cm** ☐Measured

- Items with boxes must be checked to be ordered
- Strike thru must be thru entire line and must be initialed by the physician to be valid.
- The following abbreviations CANNOT be used:
  cc u IU q.d. q.o.d. MS MS04 MgSO4
- CANNOT use trailing Zero (X.0 mg) or Leading decimal point (.X mg) (always use a leading zero)
- The metric system must be used to enter all medication orders

ALLERGIES/SENSITIVITIES

☐No Known Drug Allergies ☐Latex Allergies ☐Latex Precautions

Agents	**Reactions(s)/Notes**

NURSING/TREATMENT

NPO after:

Lab Work:

☐ Urine Pregnancy Test Day of Surgery

☐ Other Labs:

Have Operative Consent Signed for:

Additional Orders:

DO NOT WRITE BELOW THIS LINE – IF YOU NEED ADDITIONAL ORDERS, PLEASE USE PHYSICIAN ORDER SHEET

Ordering Practitioner's Signature | Print Name | Beeper Number

Date | Time | RN SIGNATURE/DATE/TIME

Children's
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1600 7th Avenue South
Birmingham, AL 35233

ECD #

MR#: LOC:

DOB:

REQUEST FOR AND CONSENT TO OPERATION(S), TRANSFUSION OF BLOOD PRODUCTS, OR OTHER PROCEDURES, AND/OR RETENTION OR DISPOSAL OF TISSUE, ORGANS OR SEVERED MEMBERS

1. **Procedure/Operation Consent:** I request, authorize and direct _____MD/DMD, my/my child's physician and/or his/her designated representative to perform upon _____
(State name of patient or "myself")
the following procedure(s) (NO ABBREVIATIONS) _____
_____
_____
which appear necessary indicated by the diagnostic studies already performed. I authorize any other therapeutic procedure that his/her judgment may dictate to be advisable for my/my child's well-being. I have reviewed my/my child's clinical condition with my/my child's physician including the anticipated benefit to be obtained from such procedures, the risks of the procedures and alternatives. My/my child's physician has explained the common risks and consequences associated with operation/procedure to my satisfaction. While no guarantee has been made as to the results of any planned treatment, I understand this is administered in the best judgment of my/my child's physician to benefit me/my child. I understand that residents, fellows, or physician assistants may assist with or perform parts of the procedures or other medical acts as deemed appropriate under the supervision of my/my child's physician, at a level of involvement deemed appropriate by my/my child's attending physician.

2. **Medical Photography:** I understand and agree that medical images such as photographs, videotaping and other digital recordings of the patient may be made at the request of the physician. I understand and agree that the nature and use of these medical images is for the diagnosis of medical conditions, medical records, consultation, teaching, and publication. These medical images involve various technologies like streaming, print and digital media. Measures will be taken to reduce or eliminate identifying features but there remains a possibility that someone may recognize me/ my child.

3. **Scientific and Educational Purposes:** I authorize the pathologist and/or the Hospital to examine, retain, use, or dispose of all tissues, organs, or members as shall be removed by operation or biopsy performed upon the patient for scientific research (including but not limited to tissue/ organ banks or institutional review board-approved research protocols), therapeutic, or teaching purposes. I understand that my/my child's identity will be concealed and my/my child's privacy maintained.

4. **Additional Services:** In the course of the above named procedure, certain unforeseen conditions may arise that may require additional services including operations, procedures, administration of medical and invasive monitoring techniques. I request that my/my child's physician, in his/her best judgment, direct any further therapeutic means to improve my/my child's condition.

_____ _____
Signature of Patient/Parent/Legal Guardian Date Time Witness to Signature Date Time

****

Physician Statement: I have discussed the procedure named above, including its relevant risks, benefits, including potential problems related to recuperation, and side effects related to alternatives including the possible results of not receiving care, treatment, and services. The patient/family understands and acknowledges that questions were answered to their satisfaction and request to proceed.

_____
Physician/Dentist Signature Date Time

****

Consent for Blood and Blood Product Transfusion: It has been explained to me that I/ my child need(s) or may need in the future a blood or blood product transfusion. I have received and read "Information about Blood and Blood Product Transfusion." I understand that no guarantees have been made concerning the outcome of this/these transfusion(s) by my/my child's physician or by Children's of Alabama. I have had the opportunity to ask questions and these have been answered by my/my child's physician. I hereby consent to this and/or possible future transfusion(s), and I understand that I may withdraw consent at any time.

Special instructions regarding transfusion: _____

_____ _____
Patient/Parent/Legal Guardian Signature Date Time Witness to Signature Date Time

Children's
of Alabama®
1600 7th Avenue South
Birmingham, AL 35233

ECD #

MR#: LOC:

DOB:

REQUEST FOR AND CONSENT TO OPERATION(S), TRANSFUSION OF BLOOD PRODUCTS, OR OTHER PROCEDURES, AND/OR RETENTION OR DISPOSAL OF TISSUE, ORGANS OR SEVERED MEMBERS

Additional Information Explained to the Patient or his / her authorized representative:

Explained by: _____
Signature Date Time

Children's
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1600 7th Avenue South
Birmingham, AL 35233

ECD #

MR#: LOC:

DOB:

INFORMATION ABOUT BLOOD AND BLOOD PRODUCT TRANSFUSION

Explanation of Procedures: As has been explained to you by your physician or care provider, you/your child needs or may need in the future a blood or blood product transfusion. A blood or blood product transfusion is when blood is taken from a volunteer or relative and given through an intravenous infusion to the person who needs it. This is called an allogeneic or unrelated transfusion. When the blood is taken from the donor, it is most often divided into its components or separate parts. This blood and/or its product is then tested and stored until it is needed. Blood may also be given and stored ahead of time by a person who knows he/she is going to or may need a blood transfusion in the near future (i.e. for elective surgery). This is called autologous transfusion.

Explanation of Types of Blood Components and Benefits:

The parts of blood (known as blood products) which may be given during a transfusion include:

- Platelets or fresh frozen plasma which prevent or control bleeding;
- Packed red blood cells, which supply the body with oxygen;
- Factor VIII, Factor IX, and Cryoprecipitate are often given to patients with hemophilia (a disease in which these factors are missing in the blood which causes these patients to bleed easily) to prevent or control bleeding;
- Granulocyte infusions to help fight infection when low white blood cell count is associated with life threatening infection; and
- Immunoglobulin to replenish immunoglobulin deficiencies to fight infection.

Before or at the time of transfusion, it will be explained to you which of these products your child (you) will be receiving. Rarely will whole blood be given. At times, it will be necessary to give the patient blood which has been treated by irradiation or washing when a patient is receiving chemotherapy or has decreased immunity.

Risks or Discomforts: Donated blood is tested according to national guidelines. Even though there is strict screening and testing of blood and blood products for HIV (the virus that causes AIDS) and other infectious diseases such as Hepatitis or Cytomegalovirus by the blood services, it is still possible that the AIDS virus or other infectious diseases may be transmitted to you/your child although the risk of this occurring is extremely low.

Other possible side effects (risks) from blood or blood product transfusions include:

- Severe allergic reaction
- Human error
- Transfusion-Related Acute Lung Injury (an immune reaction that affects a person's lungs)
- Fever, chills, rash
- Temporary decreased ability to fight infections
- Fluid overload

There is also the possibility that, in an emergency, it may not be possible to perform adequate cross-matching tests. This will make it necessary to use existing stocks of blood, which may not include the most compatible blood types, thus increasing the risk of reaction.

Alternatives: The success and availability of alternative treatments depends on you/your child's situation. Sometimes, medications can be used in order to help the body make its own blood or to prevent or control bleeding. These alternatives may not work quickly enough to assist in an emergency.

Children's
of Alabama®
1600 7th Avenue South
Birmingham, AL 35233

PATIENT NAME: _____

3 Hole 1/4 4 1/4 c-to-c

ONE DAY ADMISSION CENTER
HISTORY AND PHYSICAL EXAMINATION

Chief Complaint: _____

_____

Other: _____

Pertinent Medical History: _____

_____

_____

Drug/Food Sensitivities and Allergies:_____

Immunizations: _____ Medications: _____

Does the mother breastfeed the infant/child? ( ) Yes ( ) No

If Yes, what medications is the mother taking?_____

Bleeding tendency:_____

Family Anesthesia History:_____

Social Developmental / History: _____

PHYSICAL EXAMINATION:

HEENT (loose teeth):_____

Heart: _____

Lungs: _____

Abdomen:_____

Other: _____

IMPRESSION: _____

_____

_____

REMARKS: _____

_____

_____

_____

_____ _____/_____

Signature Date Time

_____ _____/_____

Attending Physician Signature Date Time

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PATIENT NAME: _____

3 Hole 1/4 4 1/4 c-to-c

ONE DAY ADMISSION CENTER
HISTORY AND PHYSICAL EXAMINATION

PROGRESS NOTE

DATE	NOTES
	MD
	Attending Physicians Signature

3 Hole 1/4 4 1/4 c-to-c

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Telephone (205) 638-9596

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