

ANAESTHETICS DEPARTMENT

Please complete this questionnaire and consent form as accurately as possible and present it to the charge nurse / nurse of your department on admission. This information will help us to provide the best possible care before and during the operation, adapted to your child's health condition.

Family name: _____	First name: _____	Scheduled operation: <input type="checkbox"/> Right / <input type="checkbox"/> Left _____ _____ Surgeon: _____
Date of birth: _____	Premature: <input type="checkbox"/> YES <input type="checkbox"/> NO	
Height: _____ cm	Weight: _____ kg	
Blood group: _____	GP: _____	



IS YOUR CHILD ALLERGIC TO LATEX (FOR EXAMPLE RUBBER GLOVES)? YES NO
IF "YES", PLEASE TELL YOUR PHYSICIAN AT AZ GROENINGE.



Has your child ever had an operation under a local or general anaesthetic? YES NO
If "yes", please indicate the year of the operation(s) and what the operation(s) was(/were) for:

In: _____ For: _____
In: _____ For: _____
In: _____ For: _____
In: _____ For: _____

When did you last have surgery in our hospital? In: _____

Have any members of your family ever had problems with anaesthetics? YES NO
If "yes", please give details: _____

Has your child had an unusual reaction in the past to an anaesthetic? YES NO
If "yes", please give a detailed description of this reaction:

Does your child have a heart disease? YES NO
If "yes", please give details: _____

Does your child get breathless quickly? YES NO
Does your child suffer from any breathing disorders, asthma or chronic bronchitis? YES NO
If "yes", please give details: _____

Is your child being treated for diabetes? YES NO
If "yes", please state what medication your child uses:

Does your child use insulin? YES NO
Please give name/type, dosage and, if possible, the times your child takes it:

Is your child currently receiving treatment for a nervous disorder? YES NO
If "yes", please give details: -----

Is your child currently receiving treatment for an eye disorder? YES NO
If "yes", please give details: -----

Has your child had the flu recently (over the last month)? YES NO

Has your child recently had a cold? YES NO

Does your child suffer from any other disease or disorder not mentioned here? YES NO
If "yes", please give details: -----

Does your child take any medicines? YES NO
If "yes", please state name, dosage and, if possible, the times your child takes these medicines:

Does your child suffer from prolonged bleeding after an injury or dental extraction? YES NO

Has your child ever received a blood transfusion? YES NO
If "yes", please state why and when this was:

Has your child ever had any adverse reaction to a blood transfusion? YES NO
If your child had such an adverse reaction, please give details: -----

Does your child have loose teeth? YES NO

Does your child wear:
- contact lenses? YES NO
- a hearing aid? YES NO

Has your child ever had a prosthesis or implant fitted? YES NO

Does your child have difficulty making certain movements, which are not related to the operation? YES NO
If "yes", please give details: -----

Is your child allergic to any medicines? YES NO
If "yes", please give details: -----

Is your child allergic to any fruit/vegetables such as bananas, kiwi fruit, avocados, tropical fruit, tomatoes, etc.? YES NO

Is your child allergic to plasters or to certain disinfectants? YES NO
If "yes", please give details: -----

If you want to make any additional comments or provide any additional information, please use the space below.

If the operation takes place the very day your child is admitted to hospital, he/she should be fasting, which means:

FOR CHILDREN (2-4-6 rule)
No solid food (including bottle feeding) from 6 hours before the intervention.
Glass of water up to 2 hours before the intervention.
Breast feeding allowed up to 4 hours before the intervention.

This questionnaire was completed by

- the father, mother, guardian
- the GP
- the consultant
- the father, mother, guardian with the assistance of a nurse

If you wish to talk to an anaesthetist in advance, you can make an appointment for a consultation:

t. 056 63 30 35
t. 056 63 30 30

CONSENT FORM

I, the undersigned: _____, father*, mother*, guardian* of _____ accept that my child, minor of age, will undergo a surgical procedure and consent to a general or local anaesthetic.

I will strictly follow the guidelines regarding preparation for the operation and aftercare.

- I give my consent for transfusion of blood products if medically necessary (cross out if you do not agree).
- I give my consent for using the medical data of my child anonymously in retrospective research (cross out if you do not agree).

I have carefully completed the pre-operative questionnaire and I have understood all the questions.

My child must have an empty stomach before surgery. I understand that he/she must not eat (incl. sweets) from 6 hours before the intervention. My child will not take any medicines on the morning of the operation, unless otherwise prescribed by the attending physician.

My child will not be allowed to ride a bicycle for 24 hours after the operation.
My child will not be home alone during the first 24 hours after the operation.

I also agree that my child may have to stay in the hospital should this prove to be necessary.

Date: ____ / ____ / ____

Signature:

* cross out the option that is not applicable