Alberta Health Services

Patient label placed here (if applicable) or if labels are not used, minimum information below is required.	
Name *(last, first)*	
Birthdate *(yyyy-Mon-dd)*	Gender ☐ Male ☐ Female
PHN / ULI	

Stollery Operative Services Pediatric Admission Database (Newborn – 16 years)

Parent/Legal Guardian to complete. Please print clearly. The information gathered will help your child's healthcare team to plan your child's care.

Name of person providing data		☐ Parent ☐ Legal Guardian
Home phone	Cell	Other
What languages do you speak/understand? ☐ English ☐ Other		
What languages does your child speak/understand? ☐ English ☐ Other		
What surgery is your child having?		
Allergies to medicines, foods or substances? ☐ No ☐ Yes *(list allergies and reactions)*		
Immunizations up to date? ☐ Yes ☐ No *(list what is missing)*		
Recent contact with childhood infectious diseases within the past 3 weeks or sick with cough, cold, or flu within the past 2 weeks? ☐ No ☐ Yes *(explain)*		
Does your child have any of the following? *(check all that apply)*		
☐ blood clots/bleeding problems	☐ jaw/neck problems	☐ radiation/chemotherapy
☐ breathing problems	☐ joint/bone problems	☐ seizures
☐ cancer	☐ kidney/bladder problems	☐ sleep apnea
☐ chronic pain	☐ liver problems	☐ stomach/bowel problems
☐ conditions that run in the family	☐ mental illness	☐ stroke
☐ developmental delay	☐ MRSA/VRE	☐ visual or hearing impairment
☐ diabetes	☐ muscle problems	☐ pregnancy
☐ heart problems	☐ pacemaker/external defibrillator	☐ other
If you checked any of the above, please describe below.		
Previous hospitalizations or surgery ☐ No ☐ Yes *(provide reasons and dates)*		
Has your child or anyone in your family had a problem with anesthetics? ☐ No ☐ Yes *(explain)*		
Does your child smoke or use any other substance(s) that may affect or interact with general anesthesia?		
☐ No ☐ Yes *(explain)*		

Alberta Health Services

Stollery Operative Services
Pediatric Admission Database
(Newborn – 16 years)

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Has your child ever received blood products? ☐ No ☐ Yes *(type)*

If yes, has your child ever had a reaction to the blood products? ☐ No ☐ Yes *(explain)*

List **all** medications taken at home, including prescriptions *(oral, injections, patches, inhalers, topical creams, birth control pills)* and over-the-counter *(vitamins, herbals, laxatives, acetaminophen, ibuprofen, cold/allergy preparations).*

Medication Name	Reason for Medication	How much?	How often?	Last dose taken

How does your child take medication? ☐ pill ☐ liquid ☐ by mouth ☐ g-tube

Ability to swallow ☐ no concerns ☐ other *(explain)*

Takes medications best

Does your child have any of the following? *(check all that apply)*

☐ loose teeth ☐ braces ☐ retainer ☐ hearing aid ☐ glasses ☐ contact lenses

☐ medical devices or equipment *(list)*

Type of diet ☐ regular ☐ breast fed ☐ other *(explain)*

☐ formula *(type and how often)*

☐ religious dietary restrictions *(explain)*

Date of first day of last menstrual period *(if applicable)*

Visitor restrictions ☐ No ☐ Yes *(explain)*

Other agencies involved with your child/family ☐ No ☐ Yes *(list)*

If your child has had surgery before, **describe the experience.**

Alberta Health Services

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Name *(last, first)*	
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Stollery Operative Services Pediatric Admission Database (Newborn – 16 years)

How does your child tell you that he or she is having pain?

What word(s) does your child use to describe pain?

What things upset or scare your child? *(check all that apply)*

☐ bright lights ☐ textures *(how things feel)* ☐ noises ☐ unusual smells

☐ oral issues *(things in his/her mouth)* ☐ extremely busy environments

☐ other specific fears *(describe)*

How does your child react to stressful situations or environments such as being at a hospital, waiting for a procedure, or being hungry and not able to eat? *(check all that apply)*

☐ withdraw or become quiet ☐ cry ☐ throw things ☐ attempt to run

☐ complain or whine ☐ yell or scream ☐ hit others ☐ unknown

☐ other *(describe)*

What helps your child calm down from a stressful situation? *(check all that apply)*

☐ talking with an adult ☐ playing a game ☐ listening to music ☐ walking around

☐ other *(describe)*

How does your child communicate? ☐ speaks using many words ☐ speaks using a few words

☐ hand signals ☐ American sign language ☐ other *(describe)*

☐ communication aids or visual cues *(describe)*

What is your child's level of understanding?

☐ preschool ☐ kindergarten ☐ grade 1 – 3 ☐ grade 4 – 6 ☐ grade 7 or higher

What is the best way to explain something to your child?

To the best of my knowledge, the information that I provided in this document is correct.

Parent/Legal Guardian Signature	Date *(yyyy-Mon-dd)*
Information reviewed by nurse Name and Signature	Date *(yyyy-Mon-dd)*