Great Ormond Street Hospital for Children NHS Foundation Trust

Anaesthetic Pre-Assessment Clinic

*Screening tool for those with **Parental Responsibility** to complete*

Patient name	DOB	Gender	Date completed

1	**Is your child seeing any other doctors (not your family doctor or GP) either at GOSH or another hospital?** Please give details if possible	**Yes** ☐	**No** ☐
2	**Has your child previously had an anaesthetic or operation?** If no, please go to question 4 Multiple anaesthetics ☐ At GOSH ☐ At another hospital ☐ Which? Approximate dates of previous anaesthetics or operations Did they have a pre-medication (pre-med)? Yes ☐ No ☐	**Yes** ☐	**No** ☐
3	**Has your child ever experienced any problems with an anaesthetic?** Details	**Yes** ☐	**No** ☐
4	**Has any relative of your child experienced any problems with an anaesthetic?** Details	**Yes** ☐	**No** ☐
5	**Is your child taking any regular medications at present or in the last year?** Details	**Yes** ☐	**No** ☐
6	**Is your child allergic to anything?** Details of substance and reaction Latex allergy ☐	**Yes** ☐	**No** ☐
7	**Was your child born prematurely?** If yes, how many weeks prematurely? Lung problems Yes ☐ No ☐ Ventilated Yes ☐ No ☐ For how many weeks?	**Yes** ☐	**No** ☐
8	**Are your child's vaccinations up to date?** If no, what has been omitted and why?	**Yes** ☐	**No** ☐

Does your child have or have they had:

9	**Airway problems**	**Yes ☐**	**No ☐**
	Restricted neck movement ☐ Restricted mouth opening ☐ Oversized tongue ☐ Tracheostomy ☐		
10	**Breathing problems**	**Yes ☐**	**No ☐**
	Asthma ☐ Medicated? Yes ☐ No ☐ Chronic lung disease ☐		
	Recent or recurrent chest infection ☐ Pneumonia ☐ Croup ☐ Tuberculosis (TB) ☐		
	Chronic cough or cold ☐ Obstructive sleep apnoea ☐		
	Using CPAP or BPAP currently? Yes ☐ No ☐		
11	**Heart problems**	**Yes ☐**	**No ☐**
	Congenital abnormality ☐ Surgically corrected? Yes ☐ No ☐		
	Pulmonary hypertension (PH) ☐ High blood pressure ☐ Murmur ☐		
	Other ☐ details		
12	**Kidney problems**	**Yes ☐**	**No ☐**
	Previous transplant ☐ Renal failure ☐ Other ☐		
	Details		
13	**Blood disorders**	**Yes ☐**	**No ☐**
	Bleeding or bruising problem ☐ Anaemia ☐ Sickle cell/thalassaemia ☐ Hypoglycaemia ☐		
	Other ☐ details		
14	**Seizures or fits**	**Yes ☐**	**No ☐**
	Epilepsy ☐ Controlled by medication? Yes ☐ No ☐ Febrile convulsions ☐		
	Other ☐ details		
15	**Diabetes**	**Yes ☐**	**No ☐**
	Type Regime		
16	**Other long term conditions**	**Yes ☐**	**No ☐**
	Mucopolysaccharide (MPS) ☐ Epidermolysis bullosa ☐ Neuromuscular disease ☐		
	Other ☐ details		
17	**Are your child's day to day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months?**		
	Prefer not to say ☐ No ☐ Yes, limited a lot ☐ Yes, limited a little ☐		
	If yes, please describe your child's health problem or disability. Please choose from the list below.		
	Visual impairment ☐ Hearing impairment ☐ Learning disability ☐		
	Mobility or coordination ☐ Communication ☐ Anxiety ☐		
	Needle phobia ☐ Behaviour that challenges ☐ Prefer not to say ☐		
	Autism spectrum disorder ☐ Other ☐ details		
18	**Do you have a social worker?**	**Yes ☐**	**No ☐**
	Name Organisation Telephone		
19	**Have any of the following details changed since you last came to GOSH?**	**Yes ☐**	**No ☐**
	Home address ☐ Mobile ☐ Landline ☐ Family doctor (GP) ☐		
	Please give the new details to our receptionist who will update your child's record		
20	**Would you or your child like a pre-operative ward visit?**	**Yes ☐**	**No ☐**
21	**PATIENTS ONLY – I am 16 years old or over and I would like to see the nurse or doctor by myself**	**Yes ☐**	**No ☐**

Sign	**PRINT**	**Relationship to child**