Preoperative Survey
Child ≤ 16 years Anaesthetics Department

GZA Ziekenhuizen
GasthuisZusters Antwerpen
Sint-Augustinus - Sint-Vincentius - Sint-Jozef

Name of the child: ..... Given name: .....

Date of birth: ...../...../..... E-mail: .....

Surgical intervention / examination: ..... left ☐ right ☐

Physician: .....

Date of hospitalisation: ...../...../..... Time: ..... Date of surgery: ...../...../.....

Weight: ..... kg Length: ..... cm Blood type: ..... Please bring your blood type card

Contact Person: Name: ..... Telephone: .....

Name: ..... Telephone: .....

1. Does your child have any **allergies**? Indicate what reaction you had: swelling, shortness of breath, itching, redness

- Latex yes ☐ no ☐ reaction: .....
- Contrast substances / Iodine yes ☐ no ☐ reaction: .....
- Band aids yes ☐ no ☐ reaction: .....
- Medication ..... reaction: .....
- Other ..... reaction: .....

e.g... hay fever, dyes, kiwi, bananas, food products

2. Does your child have:

Loose teeth yes ☐ no ☐ which .....

Artificial teeth yes ☐ no ☐

A hearing aid yes ☐ no ☐ left ☐ right ☐

3. Was your child born **prematurely?** yes ☐ no ☐

After a pregnancy of ..... weeks

Weight at birth: ..... kg

4. Did your child have any **surgery in the past?** yes ☐ no ☐

If so, in which year and which surgery:

In ..... For: .....

In ..... For: .....

In ..... For: .....

In ..... For: .....

Did he / she react in an unusual manner to any previous anaesthesia? yes ☐ no ☐

If so, specify as accurately as possible: .....

Did any family member ever have any problems with anaesthesia? yes ☐ no ☐

If so, specify as accurately as possible: .....

5. Was your child ever admitted to hospital? (other than for the interventions mentioned under item 4.)

If so, what for, to which hospital, with which doctor:

For: ..... Hospital: ..... Doctor: .....

For: ..... Hospital: ..... Doctor: .....

6. Is your child able to do **normal physical efforts** (running, sports...)? yes ☐ no ☐

Is your child being treated (or has it ever been) for a **heart disease** yes ☐ no ☐

which ..... Doctor:.....

Has your child ever suffered from phlebitis or thrombosis? yes ☐ no ☐

Does your child easily have nose bleeds or bruises? yes ☐ no ☐

7. Does your child wheeze when breathing? yes ☐ no ☐

Is your child quickly out of breath? yes ☐ no ☐

Is your child being treated (or has it ever been) for a **lung disease?** yes ☐ no ☐

which ..... Doctor:.....

Do people often smoke around your child? yes ☐ no ☐

8. Is / was your child being treated for a kidney disease? yes ☐ no ☐

which ..... Doctor:.....

9. Does your child suffer from **diabetes?** yes ☐ no ☐

10. Has your child ever had jaundice (type: .....)? yes ☐ no ☐

11. Does your child suffer from epilepsy? yes ☐ no ☐

Does your child suffer from paralysis or spasticity? yes ☐ no ☐

Has your child ever been treated by a neurologist or a psychiatrist? yes ☐ no ☐

which ..... Doctor:.....

12. Does your child have difficulties opening its mouth? yes ☐ no ☐

Does your child have trouble moving its head? yes ☐ no ☐

13. Does your child suffer from an infectious disease? yes ☐ no ☐

which .....

14. Has your child ever had a blood transfusion? yes ☐ no ☐

reason: .....

Did your child react in an unusual manner, which ..... yes ☐ no ☐

Do you give your permission to administer blood products if need be? yes ☐ no ☐

15. Has your child had any **fever > 38°C** the last month? yes ☐ no ☐

when?.....

Has your child had **a cold** the last month? yes ☐ no ☐

Has your child taken any **antibiotics** the last month? yes ☐ no ☐

Do you have any additional comments: .....

.....

More information on how the admission will go can be found in the brochure " Augustientje moet naar het ziekenhuis" (Augustientje goes to hospital) on our website www.anesthesie-augustinus.be. At the Sint-Jozef campus you can ask for the brochure "Opname van uw kind in het dagziekenhuis" (Your child's admission in day hospital).

☐ **I was adequately informed about the anaesthesia and the possible risks, side effects and alternatives by means of the information brochure, the website, the surgeon and / or anaesthetist and I consent.**

☐ **I consent that the type of anaesthesia and / or analgesia may be changed during surgery without my knowledge if need be.**

☐ **I consent that my data are anonymously processed for scientific research.**

This form was filled out by

Mum ☐ Dad ☐ Other ☐ .....

Surname:.....

Date: ...../...../..... Signature:

DIRECTIVES FOR AN EMPTY STOMACH. Your child can consume what follows:	
up to 6 hours before surgery	Light solid food, full liquids (milk, soup, fruit juice, soda water ...), formula for babies > 3 months
up to 4 hours before surgery	breast-feeding, formula for babies < 3 months
up to 2 hours before surgery	clear liquids: water, coffee or tea **without milk**, clear apple juice without pulp; **maximum 1 glass**
up to 1 hour before surgery	medication with a mouthful of water

These directives must be respected in case of general narcosis or loco-regional anaesthesia; failing to observe these directives may endanger your life and will lead to postponement of the surgery.

MEDICATION
Also think of inhalers, patches, eye drops, ...

Medication	Dose as listed on the packaging	Empty belly	Breakfast	Noon	Evening	Bedtime	Remarks
EXAMPLE: Product X	**250 mg**	**1**		**½**		**1**	**Mon and Thu**

Social Survey Child ≤ 16 years

- **Living situation** ☐ With parents ☐ With mother ☐ With father
  ☐ Foster parents
  ☐ Caregivers (grandparents, family ...)
  ☐ Professional care
  ☐ Other .....
- **Who will spend the night at the hospital (rooming-in):** .....
- **Language:** ☐ understands Dutch ☐ speaks Dutch ☐ other
  Child .....
  Mother .....
  Father .....
- **Food:**
  Breastfeeding
  Bottle feeding: type of food .....
  quantity (water / spoonfuls .....
  nutrition times .....
  Diverse food ☐ Meat, fish, chicken
  ☐ Fish only
  ☐ Vegetarian
  ☐ Kosher
  ☐ Fruit mash
  ☐ Chopped fruit
  Allergy to certain food products .....
  Specific feeding habits and/or diet: .....
- **Sleeping habits:** ☐ cuddly toy ☐ soother ☐ light
- **Fall prevention:**
  - Does your child have an increased risk of falling associated with the disorder and / or treatment? ☐ yes ☐ no
  - Is your child using a wheelchair? ☐ yes ☐ no
  - Does your child have a cognitive impairment? ☐ yes ☐ no
    (delayed mental development (concussion, brain tumour)?
  - Does your child suffer from a metabolic disorder (e.g. diabetes)? ☐ yes ☐ no
  - Is your child hard of hearing? ☐ yes ☐ no
  - Is your child visually impaired? ☐ yes ☐ no
- **Religion:**
  ☐ My child is being raised religiously and / or according to a specific philosophy of life .....

Is there anything else you wish to mention? .....
.....

This form was filled out on ...../...../..... (dd/mm/yyyy)

by: ☐ family (relationship) .....
☐ other (relationship) .....