MASSACHUSETTS GENERAL HOSPITAL
RADIOLOGY

MassGeneral Hospital for Children

DEPARTMENT OF PEDIATRIC RADIOLOGY
PROCEDURAL SEDATION /ANESTHESIA REQUISITION
(To Be Completed by Requesting Physician)

Today's Date ______________
Requesting MD________________________ Office Phone #_____________________

Patient's Name_________________________ MGH MRN# ______________________
Age: _________ Phone #____________________
Weight_________ Cell Phone # _______________________
Interpreter Services needed________________________(language, please)

Radiology Nursing determines the need for Sedation or Anesthesia at the time of the screening.

Urgency: ___Emergent (24-48hrs) ___Urgent (1 week) ___Routine (3 weeks) ___Other

Justification for urgency (if emergent): ____

Requesting Exam (be specific): ____

Diagnosis____

Symptoms: ____

____

Other Significant Medical Problems: ____

____

Other Exams: ☐ Blood Draw ☐ EEG ☐ US ☐ LP ☐ ECHO
(Must order additional tests separately; this sheet is only for planning anesthesia time)

Recent History and Physical:
☐ See CAS or LMR
☐ Faxed to Pediatric Radiology @ (617) 643 4334

Signature of requesting MD: ____________________________MD Date:____________ Pager #________________

PLEASE FAX TO PEDI RADIOLOGY (617) 643-4334
(*To be Completed by Radiology Nursing*)

Date Approved for sedation _________ Date Approved for anesthesia__________

Special Considerations:____

Reviewed by: __________________________________RN Date: _____________

(*To be Completed by Radiologist*)

Protocol for exam ____

Radiologist: __________________________________MD Date: ____________ Pager#________________

(*To be Completed by Scheduling*)
Date & Time of Exam ____________________ Date Family Notified: _______________
Date confirmation call made: _______________ Date Physician Notified:______________