

**** This questionnaire must be completed with a healthcare professional. ****

Personal information (ALL LINES ARE MANDATORY)

Full Name _____ Date of birth _____
 RAMQ _____ Exp : _____ Sex / Gender _____
 Address _____ Postal code _____ Weight (kg) _____ Height (cm) _____
 City _____ Phone (reachable between 7h30 et 15h30) _____

Medical follow-up (ALL LINES ARE MANDATORY)

- My child is being followed by a healthcare professional: Yes [] No []
 - If yes, please specify the name(s) and specialty(ies) : _____
- My child is taking medication (injection, pill, syrup, pump) regularly at the moment: Yes [] No []
 - If yes, please specify which ones : _____
- My child has allergies (medications, food, etc.): Yes [] No []
 - If yes, which ones : _____
- My child has already had general anesthesia or surgery: Yes [] No []
 - If yes, please specify : _____
- There have been serious OR very bad family reactions to anesthesia: Yes [] **CONSULT IF YES** No []
 - If yes, explain : _____
- Parental authority will not be present at the child's appointment (DYP or not): Yes [] No []

**Check the appropriate box for each condition and add comments if necessary
(ALL LINES ARE MANDATORY)**

Health conditions	YES, active and/or under treatment	YES, in the past and/or no active treatment	No / Never
Autism ASD NON-VERBAL	[]	[]	[]
Autism ASD VERBAL	[]	[]	[]
Sever anxiety WITH violent behaviours	[] CONSULT	[]	[]
Mental health condition WITHOUT violent behaviours	[] CONSULT	[]	[]
Epilepsy (medication or treatment needed)	[] CONSULT	[]	[]
Neurologic condition (paralysis, neuropathy, tumor...)	[] CONSULT	[]	[]
Blood condition or hereditary / familial anemia (sickle cell, auto-immune, thalassemia...)	[] CONSULT	[]	[]
Abnormal bleeding (under medication or emergency visits)	[] CONSULT	[]	[]
Immunosuppression (chemotherapy, organ transplant, etc)	[] CONSULT	[]	[]
Cardiac condition (malformation, arrythmia, abnormal valve...)	[] CONSULT	[]	[]
Chronic pulmonary condition (asthma needing medication or regular puffers, cystic fibrosis...)	[] CONSULT	[]	[]
Hormonal / endocrine condition (diabetes, thyroid condition...)	[] CONSULT	[]	[]
Sleep breathing disorder / obstructive sleep apnea <u>proven or currently investigated</u>	[] CONSULT	[]	[]

Comments (write here the name of syndromes if appropriate) : _____

***** IF AN ITEM IN THE "CONSULT" BOXES, A MEDICAL CONSULTATION IS REQUIRED :**

- A) **YOU SHOULD CONTACT THE PROFESSIONALS WHO FOLLOW UP AND OBTAIN CASE SUMMARIES.**
- B) **PARENTS/PATIENTS WITH FOLLOW-UP OUTSIDE OF QUEBEC MUST PROVIDE THE RECORD TO AGM**
- C) **PARENTS MUST PROVIDE A WAY TO REACH THEM BETWEEN 7:30 AM AND 3:30 PM**
- D) **SEND TO THE ADDRESS CONSULTATION@CLINIQUEAGM.INFO *****

I agree that during dental work, the most appropriate anesthesia will be administered to me by an anesthesiologist at the AGM Anesthesia Clinic. I acknowledge that I have been informed that the information collected will be used to ensure safe anesthesia for my child. I acknowledge that I will meet with the anesthesia team at the time of my appointment at the AGM clinic and that I will be informed at that time of the nature and risks or effects of this anesthesia. I agree that care will be done in a collaborative and safe manner at the AGM Anesthesia Clinic.

Patient / Parent / representative : _____ Date _____
 Health professional that revised the questionnaire _____ Date _____