1PORD

7114-030 (Rev. 11/07)

SDC HISTORY & MEDICATION SELF-ADMINISTRATION AUTHORIZATION

Patient's Height? _____ ft _____ inches OR _____ cm Measured? ☐ Yes ☐ No

Patient's Weight? _____ kg (pounds ÷ 2.2 = kilograms) Measured? ☐ Yes ☐ No

Pregnant? ☐ Yes ☐ No ☐ N/A Breastfeeding? ☐ Yes ☐ No ☐ N/A

Latex Screen:

☐ Yes ☐ No 1. Have you ever had a reaction to any rubber products or been told that you have a latex allergy?
☐ Yes ☐ No 2. Do you have chronic or congenital urinary or gastrointestinal conditions that have caused frequent contact with latex or rubber products (bladder caths, oral/trach suctioning, dental work, mult surgical procedures)?
☐ Yes ☐ No 3. Are you allergic to bananas, avocados, kiwi, tropical fruit and/or nuts?
☐ Yes ☐ No 4. At home or work, do you have frequent contact with latex or rubber (cleaning gloves, condoms, diaphragms)?
☐ Yes ☐ No 5. Do you have a personal or family history of contact dermatitis, hay fever, eczema, asthma or autoimmune disease?

If #1 answered Yes = latex allergy If two or more answered Yes = latex sensitivity

Latex allergy? ☐ Yes ☐ No If yes, document reaction below Latex sensitivity? ☐ Yes ☐ No

Food/Drug/Latex allergies: **Reaction:**

_____

_____

_____

_____

Current Home Medications List **(may use additional page(s) if needed)**

(Include current prescription meds, non-prescription meds, vitamins, minerals and herbal products)

MD: Check below for each med pt auth. to take during sleep study	**Drug name**	**Dose/Amt** (milligram, grams, units, etc.)	**Route** (by mouth, applied to the skin, injection, etc.)	**Frequency** (how often, how many times per day)	**Time(s) usually taken**	**Indication/Use**	**Ordering Physician**

Patient has been determined to be competent to self administer medications and may take home medication(s) per regimen as indicated above:_____ (Physician's signature/Date/Time)

patient cannot be authorized to take medications unless drug name, dose, route and frequency above is complete

To be completed by sleep lab tech on date of test: I have confirmed that the above home medication list is current to the best of my knowledge:

☐ Yes (Patient may use home medications as approved above by physician)

☐ No (Physician must be contacted for authorization for patient to use home medications different from those approved above by physician. A new order must be written by staff with authority to take verbal medication orders)

_____(Tech signature/Date/Time)

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PLACE PATIENT ID LABEL HERE

PROVIDENCE Alaska Medical Center

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TAB 1