Comfort Measures

How would you describe your/your child’s experience(s) with previous needlesticks/procedures?
☐ no problems  ☐ cries
☐ worries  ☐ very fearful  ☐ no previous experience

Comments: __________________________________________

Information: Would your child like (check all that apply):
☐ step-by-step instructions  ☐ one voice during procedure
☐ curtain pulled/privacy

People: Who would the child like to be involved in the needlestick/procedure? (check all that apply):
☐ caregiver  ☐ staff  ☐ Child Life Specialist (when available)

Position: Does the child prefer to:
☐ lie flat  ☐ sit up  ☐ be held

Watching: Does the child prefer to:
☐ watch  ☐ look away

Distraction: Would your child like (check all that apply):
☐ count out loud “1, 2, 3,” then poke  ☐ bubbles  ☐ book  ☐ toys
☐ other refocusing ideas (specify): ________________________________

Comfort Measures: Does your child use any of these comfort measures? (check all that apply)

For infants:
☐ swaddle or skin to skin
☐ pacifier
☐ sucrose

Children of all ages:
☐ imagery (e.g. my favorite place)
☐ deep breathing
☐ my own comfort item
   (stuffed animal, book, music)

Would you like to use other measures? (as possible for your procedure)
☐ Buzzy®
☐ Numbing options: __________________________
                                          __________________________
                                          __________________________
                                          __________________________

Any other information you would like to share with us about your child that may be helpful:

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........................................................................................................
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........................................................................................................
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Date: ____________________________

__________________________________________
Child’s name

Birthdate: ____________________________

Printed name of person filling out this form

Relationship to child