UC DAVIS HEALTH

COMFORT COMMITMENT

Comfort Measures

Date: _____

_____
Child's name

Birthdate: _____

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 ☐ quiet/less information

People: Who would the child like to be involved in the 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

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:

_____
Printed name of person filling out this form

_____
Relationship to child

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