Patient and Family Education

Procedural Services: Coping & Comfort Plan*

We want to understand what helps you/your child to be comfortable during your visit. After completing this questionnaire, please share it with your child's healthcare provider the day of their surgery. We will create a coping and comfort plan in your child's medical chart that helps us to know how to support both you and your child each time you visit us.

Please **select all options that apply** for your child (and you, where applicable) below.

As a reminder, we may not be able to accommodate *all* requests, but we will do our best.

My child's preferred name and pronouns are: _____

Environmental accommodations:

- ☐ Lowered lighting
- ☐ Quiet voices/decreased noise level
- ☐ White noise/music
- ☐ Limited number of people in our room at once
- ☐ Cushioning for bedrails
- ☐ Keeping door to room closed
- ☐ Keeping door to room open
- ☐ Other, please specify: _____

Medical accommodations:

- ☐ Communicate each step of the necessary medical care, when able
- ☐ Let my child to look at any devices or tools before use, when able
- ☐ Hide tools until their use becomes necessary, when able
- ☐ Model parts of necessary medical care on trusted adult, when able
- ☐ Review and sign consent forms outside of the room
- ☐ Discuss medical care outside of room
- ☐ Other, please specify: _____

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Behavioral accommodations:

- ☐ Space to rock back and forth
- ☐ Space to flap arms or hands
- ☐ Use of a device that helps with fidgeting
- ☐ Self-harming behavior precautions and accommodations
- ☐ Other, please specify: _____

The following **parts of a physical exam** may be difficult for my child:

- ☐ Eye exam
- ☐ Ear exam
- ☐ Nose exam
- ☐ Throat exam
- ☐ Belly exam
- ☐ Reflex exam
- ☐ Other, please specify: _____

The following **parts of their hospital stay**, including assessments before surgery, may be difficult for my child:

- ☐ Blood pressure measurement
- ☐ A provider listening to their lungs or heart with a stethoscope
- ☐ Wearing a hospital gown/shorts
- ☐ Wearing an ID band
- ☐ Receiving an injection or having an IV placed
- ☐ Wearing a pulse oximeter on their finger or toe
- ☐ Other, please specify: _____

My child **expresses their needs** or desires by:

- ☐ Spoken language
- ☐ American Sign Language (ASL)
- ☐ Gesturing or pointing
- ☐ Electronic communication device
- ☐ Leading someone towards what they want/need
- ☐ Other, please specify: _____

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My child **expresses pain** by:

- ☐ Crying
- ☐ Screaming
- ☐ Spoken language
- ☐ Self-injury
- ☐ Aggression
- ☐ Pointing
- ☐ Withdrawing
- ☐ Other, please specify: _____

This will **help my child cope** with necessary medical care:

- ☐ White noise
- ☐ Music
- ☐ Counting
- ☐ Deep breathing
- ☐ Giving them distance or space before/after
- ☐ Giving an explanation prior to the procedure
- ☐ Giving an explanation during the procedure
- ☐ Not giving any explanations
- ☐ Tablet/phone
- ☐ Sensory tool (e.g., play-doh, stress ball, fidget spinner, etc.)
- ☐ Other, please specify: _____

Please feel free to share any additional safety concerns or information we should know to support you and your child during your hospital visit with us on the day of your procedure.

* Adapted from: Kopecky, K., Broder-Fingert, S., Iannuzzi, D., and Connors, S. (2013). The needs of hospitalized patients with autism spectrum disorders: A parent survey. Clinical Pediatrics, 52(7), 652- 660. doi: 10.1177/0009922813485974.

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