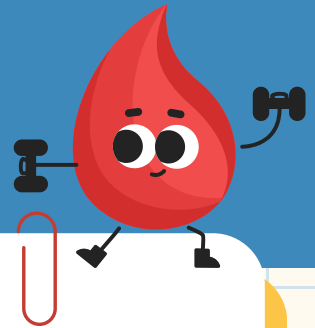


CHILD COMFORT CHECK



PATIENT INFORMATION

First Name

Last Name

Date of Birth

Order Number

COMFORT CHECK

Has your child had a blood test before? If yes, how did they respond?

Yes / No

Does your child have any fears or anxieties about needles or medical procedures?

What helps calm or comfort your child during medical visits?
(e.g. a special toy, TV, quiet environment, sitting on your lap)

Are there any specific ways we can support your child during their visit today?

