DESENSITISATION RECORD

PATIENT'S NAME _____

DATE OF BIRTH _____ **VENUE** _____

_____

_____

DATES OF VISITS: Visit 1 _____ **Visit 2** _____

_____

What has been achieved?

_____

_____

_____

Tourniquet placed on arm? _____

Tourniquet tightened? _____

Vein Located? Yes _____ No _____

Emla Cream Required? Yes _____ No _____

Arm to be Used Right _____ Left _____

Patient happy to proceed? _____

Comments:_____

_____

_____

_____