

Procedural Sedation Record

Patient Selection Criteria

Date: _____

Patient: _____ Birth Sex M F DOB ____/____/____ Weight: _____ kg Height: _____
 Physician name/phone number: _____ BMI: _____ BMI% for age: _____

- Indication for sedation: Fearful/anxious patient for whom basic behavior guidance techniques have not been successful
 Patient unable to cooperate due to lack of psychological or emotional maturity and/or mental, physical, or medical disability
 To protect patient's developing psyche
 To reduce patient's medical risk

Medical history/review of systems (ROS)	NO	YES*	Describe positive findings: _____	Airway Assessment	NO	YES*
Allergies &/or previous adverse drug reactions	<input type="checkbox"/>	<input type="checkbox"/>	_____	Limited neck mobility	<input type="checkbox"/>	<input type="checkbox"/>
Current medications (including OTC, herbal)	<input type="checkbox"/>	<input type="checkbox"/>	_____	Micro/retrognathia	<input type="checkbox"/>	<input type="checkbox"/>
Relevant diseases (including COVID)	<input type="checkbox"/>	<input type="checkbox"/>	_____	Limited oral opening	<input type="checkbox"/>	<input type="checkbox"/>
Previous sedation/general anesthetics	<input type="checkbox"/>	<input type="checkbox"/>	_____	Macroglossia	<input type="checkbox"/>	<input type="checkbox"/>
Physical/neurologic impairment	<input type="checkbox"/>	<input type="checkbox"/>	_____	Brodsky grading scale: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4		
Snoring, obstructive sleep apnea, mouth breathing	<input type="checkbox"/>	<input type="checkbox"/>	_____	Mallampati classification: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV		
Relevant birth, family, or social history	<input type="checkbox"/>	<input type="checkbox"/>	_____			
For female: Post-menarchal	<input type="checkbox"/>	<input type="checkbox"/>	_____			

ASA classification: I II III* IV* E If any *, is medical consultation indicated? NO YES Date requested: _____
 Comments: _____

Is this patient a candidate for in-office sedation? YES NO Doctor's signature: _____ Date: _____

Plan

	Name/relation to patient	Initials	Date	By
Informed consent for sedation obtained from _____	_____	_____	_____	_____
for protective stabilization obtained from _____	_____	_____	_____	_____
for dental procedures obtained from _____	_____	_____	_____	_____
Preoperative instructions reviewed with _____	_____	_____	_____	_____
Postoperative precautions reviewed with _____	_____	_____	_____	_____
Scheduled for: Date: _____ Time: _____ with Dr.: _____				

Assessment on Day of Sedation

Date: _____

Accompanied by: _____ and _____ Relationships to patient: _____

Medical Hx & ROS update	NO	YES	NPO status	Airway assessment	NO	YES	Vital Signs (if unable to obtain, ckeck <input type="checkbox"/>)
Change in medical hx/ROS	<input type="checkbox"/>	<input type="checkbox"/>	Clear liquids ____hrs	Upper airway clear	<input type="checkbox"/>	<input type="checkbox"/>	Pulse: ____/min
Change in medications	<input type="checkbox"/>	<input type="checkbox"/>	Milk, other liquids, &/or foods ____hrs	Lungs clear	<input type="checkbox"/>	<input type="checkbox"/>	SpO ₂ : ____%
Recent respiratory illness/COVID	<input type="checkbox"/>	<input type="checkbox"/>	Medications ____hrs	Tonsillar obstruction	<input type="checkbox"/>	<input type="checkbox"/> (____%)	BP: ____/____ mmHg
Pregnancy test indicated	<input type="checkbox"/>	<input type="checkbox"/>		Weight: ____kg Height: ____cm			Resp: ____/min
Date: _____ Test: _____ Results: _____				BMI: ____ BMI % for age: ____			Temp: ____°F

Pre-sedation cooperation level: Unable/unwilling to cooperate Rarely follows requests Cooperates with prompting Cooperates freely
 Behavioral interaction: Definitely shy and withdrawn Somewhat shy Approachable

Guardian was provided an opportunity to ask questions, appeared to understand, and reaffirmed consent for sedation? YES NO

Comments: _____

Safety Checklist

- Monitors tested & functioning as intended Emergency kit, suction, & high-flow oxygen
 No contraindication to procedural sedation Two adults present or extended time for discharge accepted

Drug Dosage Calculations

Sedatives

Agent _____ Route _____ mg/kg X _____ kg = _____ mg ÷ _____ mg/mL = _____ mL
 Agent _____ Route _____ mg/kg X _____ kg = _____ mg ÷ _____ mg/mL = _____ mL
 Agent _____ Route _____ mg/kg X _____ kg = _____ mg ÷ _____ mg/mL = _____ mL

Emergency reversal agents

For narcotic: NALOXONE IV, IM, or subQ Dose: 0.1 mg/kg X _____ kg = _____ mg (maximum dose: 2 mg; may repeat to maintain reversal)
 For benzodiazepine: FLUMAZENIL IV (preferred), IM Dose: 0.01 mg/kg X _____ kg = _____ mg (maximum dose: 0.2 mg; may repeat up to 4 times)

Local anesthetics (maximum dosage is based on weight; to calculate maximum volume, divide maximum dosage by agent concentration)

2% Lidocaine 4.4 mg/kg X _____ kg = _____ mg ÷ 20 mg/mL = _____ mL
 4% Articaine 7 mg/kg X _____ kg = _____ mg ÷ 40 mg/mL = _____ mL
 3% Mepivacaine 4.4 mg/kg X _____ kg = _____ mg ÷ 30 mg/mL = _____ mL
 0.5% Bupivacaine 1.3 mg/kg X _____ kg = _____ mg ÷ 5 mg/mL = _____ mL

Patient: _____ DOB ____/____/____ Date: _____

Intra- and Postoperative Management

EMS telephone number: _____

- Timeout: Caregiver present for timeout Pt ID Agreement on procedure Tooth/surgical site _____
 Planned level of sedation: Minimal Moderate Deep General anesthesia
 Monitors: Observation Pulse oximeter Precordial/pretracheal stethoscope Blood pressure cuff Capnograph EKG Thermometer
 Protective stabilization/devices: Papoose Head positioner Manual hold Neck/shoulder roll Mouth prop Rubber dam _____

TIME	Baseline	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:
Sedatives ¹																		
N ₂ O/O ₂ (%)																		
Local ² (mg)																		
SpO ₂																		
Pulse																		
Blood pressure																		
Respiration																		
CO ₂																		
Procedure ³																		
Comments ⁴																		
Sedation level [†]																		
Behavior [§]																		

- Agent _____ Route _____ Dose _____ Time _____ Administered by _____
 Agent _____ Route _____ Dose _____ Time _____ Administered by _____
 Agent _____ Route _____ Dose _____ Time _____ Administered by _____
- Local anesthetic agent _____
- Record dental procedure (e.g., Start, Completion, Recovery, Discharge)
- Enter letter on chart and corresponding comments (e.g., complications/side effects, airway intervention, reversal agent, analgesic) below:
 A. _____ B. _____ C. _____
 D. _____ E. _____ F. _____

- † Sedation level
 None (typical response/cooperation for this patient)
 Minimal (anxiolysis)
 Moderate (purposeful response to verbal commands ± light tactile sensation)
 Deep (purposeful response after repeated verbal or painful stimulation)
 General Anesthesia (not arousable)
- § Behavior/responsiveness to treatment
 Excellent: quiet and cooperative
 Good: mild objections &/or whimpering but treatment not interrupted
 Fair: crying with minimal disruption to treatment
 Poor: struggling that interfered with operative procedures
 Prohibitive: active resistance and crying; treatment cannot be rendered

Overall effectiveness: Ineffective Effective Very effective Overly sedated Was all planned treatment completed? Yes No
 Comments: _____

Discharge

<p>Criteria for discharge</p> <input type="checkbox"/> Cardiovascular function is satisfactory and stable. <input type="checkbox"/> Protective reflexes are intact. <input type="checkbox"/> Airway patency is satisfactory and stable. <input type="checkbox"/> Patient can talk (return to presedation level). <input type="checkbox"/> Patient is easily arousable. <input type="checkbox"/> Patient can sit up unaided (return to presedation level). <input type="checkbox"/> Responsiveness is at or very near presedation level <input type="checkbox"/> State of hydration is adequate. (especially if very young or special needs child incapable of the usually expected responses)	<p>Discharge vital signs</p> Pulse: ____/ min SpO ₂ : ____% BP: ____/____ mmHg Resp: ____/ min Temp: ____°F
<p>Discharge process</p> <input type="checkbox"/> Postoperative instructions reviewed with _____ by _____ <input type="checkbox"/> Transportation <input type="checkbox"/> Airway protection/observation <input type="checkbox"/> Activity <input type="checkbox"/> Diet <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Fever <input type="checkbox"/> Rx <input type="checkbox"/> Anesthetized tissues <input type="checkbox"/> Dental treatment rendered <input type="checkbox"/> Pain <input type="checkbox"/> Bleeding <input type="checkbox"/> _____ <input type="checkbox"/> Emergency contact <input type="checkbox"/> Next appointment on: _____ for _____	
<p>I have received and understand these discharge instructions. The patient is discharged into my care at _____ <input type="checkbox"/> AM <input type="checkbox"/> PM Signature: _____ Relationship: _____ After hours number: _____</p>	

Operator/Dentist Signature: _____ Chairside Assistant: _____ Monitoring Personnel Signature: _____

Postoperative call

Date: _____ Time: _____ By: _____ Spoke to: _____ Comments: _____