

# Sedation Record

**PATIENT SELECTION CRITERIA**

Date: \_\_\_\_\_

Patient: \_\_\_\_\_  M  F Age: \_\_\_ yr \_\_\_ mo Weight: \_\_\_ kg Physician: \_\_\_\_\_

- 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 &/or mental, physical, or medical disability  
 To protect patient's developing psyche  
 To reduce patient's medical risk

Medical history / review of systems (ROS)	NONE	YES*	Describe positive findings: _____	Airway Assessment	NO	YES*
Allergies &/or previous adverse drug reactions	<input type="checkbox"/>	<input type="checkbox"/>	_____	Obesity	<input type="checkbox"/>	<input type="checkbox"/>
Current medications (including OTC)	<input type="checkbox"/>	<input type="checkbox"/>	_____	Limited neck mobility	<input type="checkbox"/>	<input type="checkbox"/>
Relevant diseases, physical /neurologic impairment	<input type="checkbox"/>	<input type="checkbox"/>	_____	Micro/ retrognathia	<input type="checkbox"/>	<input type="checkbox"/>
Previous sedation/general anesthetics	<input type="checkbox"/>	<input type="checkbox"/>	_____	Macroglossia	<input type="checkbox"/>	<input type="checkbox"/>
Snoring, obstructive sleep apnea, mouth breathing	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tonsillar obstruction (___%)	<input type="checkbox"/>	<input type="checkbox"/>
Other significant findings (eg, family history)	<input type="checkbox"/>	<input type="checkbox"/>	_____	Limited oral opening	<input type="checkbox"/>	<input type="checkbox"/>

ASA classification:  I  II  III\*  IV\*  E \*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 obtained from	_____	_____	_____	_____
Pre-op instructions reviewed with	_____	_____	_____	_____
Post-op precautions reviewed with	_____	_____	_____	_____

**ASSESSMENT ON DAY OF SEDATION**

Date \_\_\_\_\_

Accompanied by: \_\_\_\_\_ Relationship(s) to patient: \_\_\_\_\_

Medical Hx & ROS update	NO YES	NPO status	Airway assessment	NO YES	Check list
Change in medical hx /ROS	<input type="checkbox"/> <input type="checkbox"/>	Clear liquids ___ hrs	Upper airway clear	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Appropriate transportation home
Change in medications	<input type="checkbox"/> <input type="checkbox"/>	Milk, other liquids	Lungs clear	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Monitors functioning
Recent respiratory illness	<input type="checkbox"/> <input type="checkbox"/>	&/or foods ___ hrs	Tonsillar obstruction (___%)	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Emergency kit, suction, & O <sub>2</sub> available
Weight: ___ kg		Medications ___ hrs			

Vital signs (If unable to obtain, check  and document reason: \_\_\_\_\_)

Blood pressure: \_\_\_ / \_\_\_ mmHg Resp: \_\_\_ /min Pulse: \_\_\_ /min Temp: \_\_\_ °F SpO<sub>2</sub>: \_\_\_ %

Comments: \_\_\_\_\_  
 \_\_\_\_\_

- Pre-sedation cooperation level:  Unable/unwilling to cooperate  Rarely follows requests  Cooperates with prompting  Cooperates freely  
 Behavioral interaction:  Definitively shy and withdrawn  Somewhat shy  Approachable  
 Guardian was provided an opportunity to ask questions, appeared to understand, and reaffirmed consent for sedation?  YES  NO

**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

**Reversal agent**

For narcotic: NALOXONE IV, IM, or subQ Dose: 0.01 mg/kg X \_\_\_\_\_ kg = \_\_\_\_\_ mg (May repeat after 2-3 minutes)  
 For benzodiazepine: FLUMAZENIL IV Dose: 0.01 mg/kg X \_\_\_\_\_ kg = \_\_\_\_\_ mg (NOT to exceed 0.2 mg/min & total dose of 1 mg)

**Local anesthetics (maximum dosage based on weight)**

Lidocaine 2% (34 mg/1.7mL cartridge)	4.4 mg/kg X _____ kg = _____ mg (not to exceed 300 mg total dose)
Articaine 4% (68mg/1.7mL cartridge)	7 mg/kg X _____ kg = _____ mg (not to exceed 500 mg total dose)
Mepivacaine 3% (51 mg/1.7 mL cartridge)	4.4 mg/kg X _____ kg = _____ mg (not to exceed 300 mg total dose)
Prilocaine 4% (68 mg/1.7mL cartridge)	6 mg/kg X _____ kg = _____ mg (not to exceed 400 mg total dose)
Bupivacaine 0.5% (8.5mg/1.7mL cartridge)	1.3 mg/kg X _____ kg = _____ mg (not to exceed 500 mg total dose)

## SEDATION RECORD

**INTRAOPERATIVE MANAGEMENT & POST-OPERATIVE MONITORING** EMS telephone number: \_\_\_\_\_  
 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 <sup>1</sup>																	
N <sub>2</sub> O/O <sub>2</sub> (%)																	
Local <sup>2</sup> (mg)																	
O <sub>2</sub> sat																	
Pulse																	
BP																	
Resp																	
CO <sub>2</sub>																	
Procedure <sup>3</sup>																	
Comments <sup>4</sup>																	
Sedation level*																	
Behavior*																	

1. Agent \_\_\_\_\_ Route \_\_\_\_\_ Dose \_\_\_\_\_ Time \_\_\_\_\_ Administered by \_\_\_\_\_  
 Agent \_\_\_\_\_ Route \_\_\_\_\_ Dose \_\_\_\_\_ Time \_\_\_\_\_ Administered by \_\_\_\_\_  
 Agent \_\_\_\_\_ Route \_\_\_\_\_ Dose \_\_\_\_\_ Time \_\_\_\_\_ Administered by \_\_\_\_\_

2. Local anesthetic agent \_\_\_\_\_

3. Record dental procedure start and completion times, transfer to recovery area, etc.

4. Enter letter on chart and corresponding comments (eg. complications/side effects, airway intervention, reversal agent, analgesic) below

A. \_\_\_\_\_ C. \_\_\_\_\_  
 B. \_\_\_\_\_ D. \_\_\_\_\_

Sedation level\*

- None (typical response/cooperation for this patient)
- Mild (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

Additional comments/treatment accomplished: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### DISCHARGE

Criteria for discharge <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 pre-sedation level). <input type="checkbox"/> Patient is easily arousable. <input type="checkbox"/> Patient can sit up unaided (return to pre-sedation level). <input type="checkbox"/> Responsiveness is at or very near pre-sedation level (especially if very young or special needs child incapable of the usually expected responses). <input type="checkbox"/> State of hydration is adequate	Discharge vital signs Pulse: _____/min SpO <sub>2</sub> : _____% BP: _____/_____ mmHg Resp: _____/min Temp: _____°F
Discharge process <input type="checkbox"/> Post-operative 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: _____	
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 phone number: _____	

Operator signature: \_\_\_\_\_ Chairside assistant: \_\_\_\_\_ Monitoring personnel signature: \_\_\_\_\_

POST OP CALL Date: \_\_\_\_\_ Time: \_\_\_\_\_ By: \_\_\_\_\_ Spoke to: \_\_\_\_\_ Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_