Sedation Record/History Sheet

Patient's Name:_______________________________ Date:_______________

Procedure being performed:____

ASA Classification: I II III IV

Prep At:____________ AM/PM NPO:_________________

Patient History Reviewed:_______________________________ Med: Y / N

Pre-Op Vital Signs: BP______ Pulse_____ Resp______

Saturation Appearance:__________________________ Consent Form Signed: Y / N

Medication(s)	**Time**	**Amt**	**Running Total**

Intra-Op Vital Signs (every five minutes)

Time______AM/PM BP______ Pulse______ Resp_______ O2 Saturation______________
Time______AM/PM BP______ Pulse______ Resp_______ O2 Saturation______________
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Time______AM/PM BP______ Pulse______ Resp_______ O2 Saturation______________
Time______AM/PM BP______ Pulse______ Resp_______ O2 Saturation______________

O2 by nasal mask: Time Started_______AM/PM Flow:________________________

IV Discontinued at:_________AM/PM

Post-Op Vital Signs: BP______ Pulse______ Resp_____ O2 Saturation___________

Release Vital Signs: BP______ Pulse______ Resp_____ O2 Saturation___________

Time, Release to whom, and condition of patient:

____

Assistant Initials

____

_________________________ _________________________
Responsible Party Signature Doctor Signature

Sedation Record

Patient: ______________________________ Date: ________________
Dx: ____
Procedure: ____
Dentist: ____________________ Assistants: ____________________
ASA: I II III ____________________

PRE-ANESTHESIA CHECKLIST:

1. Pre-med _______ Time _______AM/PM
2. ( ) Patient chart reviewed
3. ( ) Responsible adult/driver __________
4. ( ) NPO 8 hrs
5. ( ) Consent signed
6. ( ) Pre-op Checklist signed
7. ( ) Dentures removed

MONITORS
___EKG ___BP Cuff ___SAO2

O2: ____L/min N20: _____%

Start Time: ___________
Initial BP: ___________ Initial HR: ____________ Initial SpO2 % _______________

IV Site: ____________________________
Fluid: ____________________________
IV Size: ____________________________
Bite Block: Yes No Right Left

DISCHARGE CRITERIA

1. ( ) **O** oriented to time and space
2. ( ) **N** nausea and vomiting controlled
3. ( ) **T** taking fluids by mouth
4. ( ) **H** hematologic stability (EKG,BP)
5. ( ) **E** escort present
6. ( ) **W** wound not bleeding
7. ( ) **A** airway clear
8. ( ) **Y** "yes, I want to go home"
9. ( ) POIG O/W

Anesthetics	Carps
2% Lidocaine 1:100k epi	
4% Citanest Plain	
4% Septocaine 1:100k epi	
0.5% Bupivicaine 1:200k epi	

MEDICATIONS

Time	Versed	Fentanyl	Decadron	Other
Totals				

COMMENTS/COMPLICATIONS:____
____

End Time: ___________
Final BP: ___________ Final HR: ____________ Final SpO2 % _______________

Pt. Discharged to: ____________________Escort Signature______________________

Sedation Case and Drug Log

DRUG: Versed 1mg/ml						
Name	**Date**	**Drawn**	**Given**	**Wasted**	**Totals**	**Signature**

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 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)	NONE	YES*	Describe positive findings:
Allergies &/or previous adverse drug reactions	☐	☐	______________
Current medications (including OTC)	☐	☐	______________
Relevant diseases, physical/neurologic impairment	☐	☐	______________
Previous sedation/general anesthetics	☐	☐	______________
Snoring, obstructive sleep apnea, mouth breathing	☐	☐	______________
Other significant findings (eg, family history)	☐	☐	______________

Airway Assessment	NONE	YES*
Obesity	☐	☐
Limited neck mobility	☐	☐
Micro/retrognathia	☐	☐
Macroglossia	☐	☐
Tonsillar obstruction (___%)	☐	☐
Limited oral opening	☐	☐

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	Checklist
Change in medical hx/ROS	☐	☐	Clear liquids ____hrs	Upper airway clear	☐	☐	☐ Appropriate transportation home
Change in medications	☐	☐	Milk, other liquids, &/or foods ____hrs	Lungs clear	☐	☐	☐ Monitors functioning
Recent respiratory illness	☐	☐		Tonsillar obstruction (___%)	☐	☐	☐ Emergency kit, suction, & O_2 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_2:______%

Comments: ____

Presedation 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

Emergency reversal agents

For narcotic: NALOXONE IV, IM, or subQ Dose: 0.1 mg/kg X _____ kg = _____mg (Maximum dose: 2 mg; may repeat)
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 based on weight)

Lidocaine 2%	(34 mg/ 1.7 mL cartridge)	4.4 mg/kg X ______kg = ______mg	(not to exceed 300 mg total dose)
Articaine 4%	(68 mg/ 1.7 mL 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/ 1.7 mL cartridge)	6 mg/kg X ______kg = ______mg	(not to exceed 400 mg total dose)
Bupivacaine 0.5%	(8.5 mg/ 1.7 mL cartridge)	1.3 mg/kg X ______kg = ______mg	(not to exceed 90 mg total dose)

Intraoperative Management and 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[1]																	
N_2O/O_2 (%)																	
Local[2] (mg)																	
SpO_2																	
Pulse																	
BP																	
Resp																	
CO_2																	
Procedure[3]																	
Comments[4]																	
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. ______________________________ B. ______________________________
   C. ______________________________ 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
- ❑ Cardiovascular function is satisfactory and stable.
- ❑ Airway patency is satisfactory and stable.
- ❑ Patient is easily arousable.
- ❑ Responsiveness is at or very near presedation level (especially if very young or special needs child incapable of the usually expected responses).
- ❑ Protective reflexes are intact.
- ❑ Patient can talk (return to presedation level).
- ❑ Patient can sit up unaided (return to presedation level).
- ❑ State of hydration is adequate.

Discharge vital signs
Pulse: ______/ min
SpO_2: ______%
BP: ______/______ mmHg
Resp: ______/ min
Temp: ______°F

Discharge process
- ❑ Post-operative instructions reviewed with ______________________ by ______________________
  - ❑ Transportation ❑ Airway protection/observation ❑ Activity ❑ Diet ❑ Nausea/vomiting ❑ Fever ❑ Rx ❑ Anesthetized tissues
  - ❑ Dental treatment rendered ❑ Pain ❑ Bleeding ❑ ______________ ❑ Emergency contact
- ❑ Next appointment on: ______________________ for ______________________

I have received and understand these discharge instructions. The patient is discharged into my care at ________ ❑ AM ❑ PM
Signature: ______________________ Relationship: ______________ After hours number: ______________

Operator Signature: ______________________ Chairside Assistant: ______________________ Monitoring Personnel signature: ______________________

Post-op call

Date: __________ Time: ________ By: ________ Spoke to: ______________ Comments: ______________________

Oral Sedation information and Consent form

This form is intended to document the discussion we have had regarding your planned conscious sedation procedure.

The medications we use are typically either Triazolam (Halcion), Lorazepam (Ativan), Diazepam (Valium) or Midazolam (Versed). These medications can greatly minimize anxiety that may be associated with going to the dentist. In a relaxed state, you will still be able to communicate with the dentist while treatment is being performed. Even though it is safe, effective and wears off rapidly after the dental visit, you should be aware of some important precautions and considerations.

Benefits of conscious sedation include reduced awareness of unpleasant sights, sounds and sensations associated with the procedure along with reduced anxiety. Most patients fall asleep, but not always.

Risks of conscious sedations include nausea/vomiting, allergy to medication, irritation and/or pain/swelling to skin and veins (IV only), breathing problems, brain damage, cardiac arrest and death.

I understand that it is **critically important** that I fully discuss my complete medical history with the dentist before sedative medications are administered especially any medications I'm taking.

You should not use these medications if you are PREGNANT, breast feeding, or have significant liver or kidney disease. ________(please initial)

Tell the doctor if you are taking the following medications as they can adversely interact with the sedation medications: nefazodone (Serzone); cimetidine (Tagamet, Tagamet HB, Novocimetine or Peptol); levadopa (Dopar or Larodopa) for Parkinson's disease; antihistamines (such as benadryl and travist); verapamil (Calan); diltiazem (Cardizem); erythromycin and the azole antimycotics (nizoral, biaxin, orporanox); HIV drugs indinavir and nelfinovir; and alcohol. Grapefruit juice should also be avoided. Taking recreational/illicit drugs can also cause untold reactions.

The dentist has reviewed the written instructions with me including expectations regarding food/drink intake, escort and activity after the sedation.

Sedation can be administered by multiple routes. Dr. has discussed these options with me. I also understand that the sedation plan may need to be changed on the day of the procedure. I also acknowledge that no guarantee has been made as to the results that may be obtained.

During the discussion, I have had my questions answered to my satisfaction.

I, ________________________________, request and authorize Dr. to administer oral conscious sedation medications and/or nitrous oxide/oxygen conscious sedation to me in conjunction with the planned endodontic procedure.

The reason I am asking for these medications is:____.

Patient/Guardian ____Date _______________

Witness:_______________________________________Doctor:_______________________________________

IV Sedation Informed Consent

I understand that undergoing IV sedation includes possible inherent risks such as, but not limited to the following:

1. Complications due to drugs which include but are not limited to: nausea, vomiting, swelling, bleeding, infection, numbness, allergic reaction, stroke, and heart attack. Some of these complications, although rare, may require hospitalization and may even result in death.

2. Bruising or tenderness of the IV induction site may occur. Some sedative agents may cause a burning or itching sensation in the place the IV is administered. Swelling may be caused from excess IV fluid entering surrounding tissues and may take several days to resolve. Tenderness, bruising, or swelling can be treated with warm moist heat applied to the site.

3. Need for limitation of food and drink. I understand that the patient must refrain from any food or drink after midnight for a morning appointment. Prior to an afternoon appointment, the patient is limited to a light breakfast no later than six hours before treatment time and clear liquids up to three hours before treatment. No milk.

4. Changes in health are important, including fevers or colds. I am expected to convey this information to the dentist prior to a planned appointment when IV sedation is involved.

5. A responsible adult must accompany the patient at the time of discharge. I understand that the patient must not drive a vehicle or take a bus or taxi after undergoing IV sedation.

6. Women: Anesthetics and other medications may be harmful to an unborn child and may cause birth defects or spontaneous abortion. I accept full responsibility for informing the dentist or attending anesthetist of a suspected or confirmed pregnancy.

I have been given the opportunity to ask any questions regarding the nature and purpose of IV sedation and have received answers to my satisfaction. I do voluntarily assume any and all possible risks, including the risk of substantial harm, if any, or even death which may be associated with any phase of receiving IV sedation in hopes of obtaining the desired results, which may or may not be achieved. No guarantees or promises have been made to me concerning my recovery and results of the treatment to be rendered. The fee(s) for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize Dr.   to render any treatment necessary or advisable to my dental conditions, including any and all anesthetics and medications for my own benefit or the benefit of my minor child or ward.

______________________	______________________	______________
Patient's name	Signature of patient, legal guardian, or authorized representative	Date