Dr. Jay Patel
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DENTAL SEDATION SERVICES

SEDATION REQUEST FORM

Dental Office:	**Doctor Name:**
Office Number:	**Office Contact:**

Patient Name	**Cell:**	**Email:**
DOB:	**Home:**	

Height: **Weight:** **Age:** **Sex:**

Mallampati: **I** **II** **III** **IV** **Brodsky:** **0** **I** **II** **III** **IV**

DATE REQUESTS: (START TIME is when you would like patient in the chair. The doctor will typically arrive 30 minutes prior for setup)

	Date:	Start Time:
First Choice:		
Second Choice:		
Additional Choices:		

Estimated Treatment Time: _____

	Reason For Sedation:
	Nitrous Sedation failed
	Oral Sedation – Not a candidate/failed
	Severe dental phobia
	Overactive gag reflex
	Special Needs
	Other:

	Dental Treatment:
	Restorations
	Crown/Bridgework
	Extractions
	Root canal/Pulp Treatment
	Implants
	Periodontal Surgery
	Treatment Plan w/ Same day treatment
	Other:

Any other information for the anesthesiologist: _____