

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: _____