

The Accolade Dental Centre - Parenteral Conscious Sedation Record

PATIENT INFORMATION

Patient (FullName):

Birthdate – M/D/Y: Gender (M/F): Date – M/D/Y:

Dental Procedure(s):

MEDICATIONS (Name, Dose, Frequency):

ALLERGIES (Agent, Reaction):

ESCORT (Verified Pre-Sedation) Name: _____

Relationship: Phone #:

ASA: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III		AGE:	
WT (kg):		HT:	
BMI:			
NPO: <input type="checkbox"/> Y <input type="checkbox"/> N		Last Solids:	
		Last Fluids:	
Review of Systems: <input type="checkbox"/> WNL* <input type="checkbox"/> Teeth <input type="checkbox"/> Airway <input type="checkbox"/> C.V.S			
<input type="checkbox"/> Resp <input type="checkbox"/> Neuro <input type="checkbox"/> GI <input type="checkbox"/> GU <input type="checkbox"/> Prev. Anesth. Prob.			
Physical Exam:			
Assessment:			

<input type="checkbox"/> Emergency oxygen, drugs and equipment checked (All Alarms ON) prior to sedation				
Monitors: <input type="checkbox"/> NIBP <input type="checkbox"/> SpO ₂ <input type="checkbox"/> ECG <input type="checkbox"/> ETCO ₂ <input type="checkbox"/> Other _____				
Pre-Sedation Vitals:	BP	HR	O ₂ Sat.	RESP.
Intended Level of Sedation: <input type="checkbox"/> Minimal <input type="checkbox"/> Moderate				
Deepest Level of Sedation Obtained: <input type="checkbox"/> Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> Deep <input type="checkbox"/> General				

Indication(s) for Sedation:

Anxiolytics/Sedatives Taken Night Before Dental Appointment:

Name: _____ Dose: _____ Time: _____

Anxiolytics/Sedatives Taken Prior to Arrival to Dental Facility:

Name: _____ Dose: _____ Time: _____

Non-Sedative/Sedative Premedication:

Name: _____ Dose: _____ Time: _____

POST SEDATION RECOVERY

Time								
BP								
Pulse								
Resp.								
SpO ₂								

DISCHARGE CRITERIA

Oriented to person/place/time: <input type="checkbox"/> Y <input type="checkbox"/> N				
If under age 9: <input type="checkbox"/> Protective reflexes <input type="checkbox"/> Easily arousable <input type="checkbox"/> Sit up unassisted				
Discharge Vitals:	BP	HR	O ₂ Sat.	RESP.
Vital Signs Stable: <input type="checkbox"/> Y <input type="checkbox"/> N				
Pre-sedation Level of Ambulation: <input type="checkbox"/> Y <input type="checkbox"/> N				
Written Post-Sedation Instructions Given: <input type="checkbox"/> Y <input type="checkbox"/> N				
Verbal Post-Sedation Instructions Given: <input type="checkbox"/> Y <input type="checkbox"/> N				

RECOVERY SUPERVISOR:

In the Company of:

Name: _____

Relationship:

Phone #:

Patient Left the Facility at: _____ am/pm

SIGNATURES

DDS:

SEDATION PROVIDER:

RN/RT:

DA:

SEDATION	
1	1.0
2	2.0
3	3.0
4	4.0
5	5.0
6	6.0
7	7.0
8	8.0
9	9.0
10	10.0
11	11.0
12	12.0
13	13.0
14	14.0
15	15.0
16	16.0
17	17.0
18	18.0
19	19.0
20	20.0
21	21.0
22	22.0
23	23.0
24	24.0
25	25.0
26	26.0
27	27.0
28	28.0
29	29.0
30	30.0
31	31.0
32	32.0
33	33.0
34	34.0
35	35.0
36	36.0
37	37.0
38	38.0
39	39.0
40	40.0
41	41.0
42	42.0
43	43.0
44	44.0
45	45.0
46	46.0
47	47.0
48	48.0
49	49.0
50	50.0
51	51.0
52	52.0
53	53.0
54	54.0
55	55.0
56	56.0
57	57.0
58	58.0
59	59.0
60	60.0
61	61.0
62	62.0
63	63.0
64	64.0
65	65.0
66	66.0
67	67.0
68	68.0
69	69.0
70	70.0
71	71.0
72	72.0
73	73.0
74	74.0
75	75.0
76	76.0
77	77.0
78	78.0
79	79.0
80	80.0
81	81.0
82	82.0
83	83.0
84	84.0
85	85.0
86	86.0
87	87.0
88	88.0
89	89.0
90	90.0
91	91.0
92	92.0
93	93.0
94	94.0
95	95.0
96	96.0
97	97.0
98	98.0
99	99.0
100	100.0

** LOS = Level of Sedation