American Pediatric Sedation Center

Sedation and Hospital Referral Form

Patient's Name: ___________________________________ Date of Birth: ________________________ Patient's Age: _________

Parent or Legal Guardian's Name: ____________________________________ Phone number: _____________________________

Parent or Legal Guardian's Email: ____________________________________ Referral for (*check one*): ☐ **Sedation** ☐ **Hospital**

Criteria for Sedation:

1. Weight: at least 30 lbs (13.5kg)
2. Age: at least 3 years old
3. Health status (ASA classification): Healthy (ASA I) or mild systemic disease/illness, e.g. intermittent asthma (ASA II)

Indication(s) 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

☐ Extensive dental treatment

If referring a patient to the hospital for comprehensive dental treatment, please ensure that he/she meets the criteria stipulated by Joe DiMaggio Children's Hospital on the attached Hospital GA Form. For all patient referrals, please include copies of patient's dental radiographs and treatment plans. ***Please email this form, along with the patient's x-rays and treatment plan, to sedation@americanpediatricdental.com in an encrypted format (i.e. in Outlook by typing "ENCRYPTED" in the subject heading).***

Name of Referring Dentist: ____________________________________ Office Name: ____

Office Address: ____ City: ______________________ State:________ Zip:________

Office phone number: ____ Fax: ______________________ Email: ____________________

____ ___________________________________

Signature of Referring Dentist Date

American Pediatric Sedation Center
18501 Pines Blvd, Suite 211, Pembroke Pines, FL 33029. Ph: (954)-417-1330 Fax: 954-637-1955
AmericanPediatricDental.com Email: sedation@americanpediatricdental.com