American Pediatric Sedation Center

Sedation 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**

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

For all patient referrals, please include copies of patient's dental radiographs and treatment plans.

Name of Referring Dentist: _____ Office Name: _____

Office Address: _____ City: _____ State:_____ Zip:_____

Office phone number: _____ Fax: _____ Email: _____

_____ _____

Signature of Referring Dentist Date

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