COASTAL KIDS
DENTISTRY & ORTHODONTICS

Deep Sedation/IV Sedation Referral Form

Phone: (858) 648-5437 / Email: sedation@coastalkidsdo.com
Website: CoastalKidsDO.com

Date of Referral: _____ **Referred by Dr.** _____

Introducing: _____ **Age:** _____

Patient's Phone #: _____ **Name of Parent:** _____

Tell us more about the patient:

- ASA classification? ☐ ASA 1 ☐ ASA 2 ☐ ASA 3

  Please specify medical history if other than ASA 1

  _____

- Please select Airway Classification:

  Mallampati: I II III IV

  Brodsky: 1 2 3 4

- Does the patient currently have pain or an infection? ☐ Yes ☐ No
- What is the behavior of the patient?

  ☐ Poor ☐ Fair ☐ Good ☐ Excellent
- Has treatment been attempted before? ☐ Yes ☐ No
- Does the patient's parent(s) understand the recommended treatment and sedation? ☐ Yes ☐ No
- How many quadrants of treatment are needed? _____

Are their records transferred? ☐ No ☐ Emailed to office

Radiographs: Date Taken: _____

☐ Sent with parents ☐ Emailed to office ☐ None Available

Recommended treatment:

_____

_____

Carmel Valley
12395 El Camino Real #218
San Diego, CA 92130

Eastlake
2015 Birch Rd., Unit 103
Chula Vista, CA 91915

Santee
110 Town Center Pkwy, Ste A
Santee, CA 92071

South Bay
662 Dennery Rd., Ste 103
San Diego, CA 92154