HAPPY CHILDREN
PEDIATRIC DENTAL SEDATION CENTER

Medical Clearance for IV Sedation

Date: _____
Attn: _____
Patient: _____ Birthdate: _____

Dear Dr._____
Our mutual patient, _____ is scheduled for dental treatment.

Treatment may include:

__ Cleaning (simple or deep)
__ Radiographs
__ Fillings, Crowns, Bridges
__ Local anesthetic (with epinephrine)
__ Root Canal Therapy
__ Nitrous oxide
__ Extraction (simple or surgical)
X Other In-office IV sedation with Propofol and/or Ketamine

The patient has indicated the following medical conditions:

_____

Please evaluate this patient's medical history and advise us of any special considerations that should be made.

- Antibiotic prophylaxis: Yes ____ No ____
- Interruption of anticoagulants: Yes ____ No ____
  How long before and after treatment: _____
- Anesthetic restrictions: Yes ____ No ____
- Is Epinephrine, OK? Yes ____ No ____

Type of antibiotic allowed/recommended: _____

Type of pain medication allowed/recommended: _____
Any additional comments:

_____
_____

Physician Name (please print): _____
Physician Signature: _____
Date: _____

Please have physician sign and fax or email to: ( ) 770-541-9132 ( ) sedation@happychildrensdentist.com

We appreciate your assistance in providing optimum care for this patient.

Jina Yoo, DDS

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