Sedation Request Form

Diagnostic Imaging with Sedation for ____

Patient's Name DOB

In order to schedule the appropriate sedation for your patient, please consider the following and check the most appropriate.

______ Meets ALL criteria below:

-Age 6mo to 18 yrs

-No airway compromise

-Absence of severe cardiopulmonary disease (eg. well-controlled asthma, isolated seizure)

______ Meets ANY criteria below:

-Age < 6mo or >18 yrs

-Potentially difficult airway

-Severe cardiopulmonary disease (OSA, pulmonary HTN)

-Difficult IV start or inability to cooperate with awake IV placement

Once we have this information we will schedule the appointment.

Please sign this sheet and fax it to 983-6722. Thank You.

____ ____________________

Print MD's Name MD's Signature Date

Imaging Use Only	**1st Choice**	**2nd Choice**	**3rd Choice**	
Date:				
SED Time:				
Scan Time:				
Case #:				