SWEET DREAMS

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Pre-Anesthesia Instructions

- **Fasting before anesthesia is essential for patient safety and prevention of aspiration.** Failure to follow fasting instructions will require cancellation of anesthesia, and require you to reschedule your appointment. Deposits paid for the procedure may be forfeit.
    - **Pediatric patients (0-12 years old)** : May eat a light meal 6 hours before procedure start, breast milk 4 hours before, and small amounts of clear liquid (such as water, Gatorade, or apple juice) no sooner than 2 hours before the scheduled procedure start time.
    - **Adult patients:** May eat a light meal 8 hours before the procedure starts, and small amounts of clear liquid (such as water, Gatorade or apple juice) no sooner than 2 hours before the scheduled procedure start time.
    - Patients with a strong history of gastric reflux or gastric motility problems should fast from food and liquid for 10-12 hours before the scheduled procedure start time.
- Take prescribed medications as instructed with a small sip of water at regular prescribed time. Bring respiratory inhalers, diabetes testing supplies and insulin with you to your appointment if applicable.
- Wear loose clothing with short sleeves to your appointment. You will receive an IV in your arm. Pediatric patients may receive an injection in their arm as well. Short sleeved clothing will facilitate IV or injection administration and will allow for easier vital sign monitor placement. It is recommended that you remove jewelry, makeup, and contact lenses prior to your appointment.
- If you are currently ill, have a fever of 100 °F or greater, a productive cough, sore throat, excessive nasal congestion, or have had a recent significant change in health, we may need to wait until you have returned to your normal health. Please contact your doctor to reschedule your appointment.
- Make arrangements for a responsible adult to drive you home after anesthesia.
- Parents, please make arrangements for your other children to be cared for on the day of your child's procedure. Your child will need your full attention and care. Please note that parents will not be allowed in the surgical suite during the procedure.
- Be prepared to pay for anesthesia on the day of service.

After Anesthesia Instructions

- It is normal to experience dizziness, blurred vision, drowsiness, eye twitching, confusion, or forgetfulness after anesthesia. Although less common, some patients will have mild nausea, vomiting, mild fever (less than 100 °F), or mild skin rashes after anesthesia. Any of these symptoms are normal and should end in 2-4 hours.
- Abnormal symptoms include nausea or vomiting lasting more than 6 hours, uncontrolled bleeding, fever greater than 100 °F, excessive pain, lack of appetite, or excessive sleepiness 6 hours after the procedure. Please call your Doctor or Anesthesia Provider if these conditions occur.
- Call 911 or go to the nearest hospital if the patient has difficulty breathing, or a sudden change in alertness or is difficult to arouse. These symptoms may be signs of serious emergency conditions.
- You may begin eating and drinking as tolerated. We recommend you start with liquids and soft foods and then work back into a regular diet. If you become nauseated, return to liquids and soft foods.
- Go home and rest after your procedure. You will have poor balance and impaired mental judgment after anesthesia, and will require a responsible adult to supervise you. Avoid driving a vehicle, climbing, playgrounds, swings, bicycle riding, or other activities requiring muscle coordination and mental judgment. Children should not attend school on the day of anesthesia. Return to normal activities the day after anesthesia.
- You may take Acetaminophen (Tylenol) and/or Ibuprofen (Advil/Motrin) for pain control after your procedure if recommended by your doctor. Take these medications as directed on the medication package. These medications can be taken together every 6-8 hours. You may also alternate between these medications every 3-4 hours.
    - You received Toradol in your IV @ _____
    - Acetaminophen (Tylenol) can be taken @ _____
    - Ibuprofen (Advil / Mortrin) can be taken @ _____
- Please call the number at the top of this form for questions or concerns. Thank you for letting us care for you.

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Patient Information and Consent Form

Date _____ Name _____ Age _____ DOB _____ Gender _____
Weight _____ lbs. Allergies to Medicines _____ Medications taken routinely _____
Procedure today_____Doctor_____
Previous surgeries_____Problems with Anesthesia_____
Is there a history of problems with anesthesia in your family?_____

Check any of the following conditions which may apply to the patient:

___Large tonsils	___High Blood Pressure	___Kidney Problems	___Cancer
___Sleep Apnea / Snoring	___Irregular Heartbeat	___Diabetes (Type 1 or 2)	___Alcohol Use
___Asthma	___Heart Attack / Chest Pain	___Liver Problems	___Substance Abuse
___Shortness of Breath	___Stroke	___Thyroid Problems	___Anxiety / ADHD
___Smoking / Vaping	___Blood Clot	___Headaches	___Autism
___Exposure to Smoking	___Bleeding Disorder	___Epilepsy / Seizures	___Developmental Delay
___Chronic cough	___Numbness / Paralysis	___Acid Reflux	___Pregnant

___Other_____
Disabilities / Restrictions / Preferences _____
Last time patient had something to drink _____ to eat _____
Do you or any member of your family have any concerns or questions about anesthesia?_____

Consent for Anesthesia

I give my consent for anesthesia to be provided as requested by my Doctor by a certified nurse anesthetist associated with Sweet Dreams, LLC. I certify that I have read, understand, and have fully complied with the pre-anesthesia instructions and intend to fully follow the post-anesthesia instructions. Although rare, patients can suffer allergic reactions, circulatory or respiratory failure, organ damage, nerve damage, brain damage, or even death. If the patient requires transport to or treatment at another facility, I understand that I am financially responsible for the total costs incurred. I acknowledge that my questions and concerns have been addressed by my Doctor or Anesthesia Provider. I am aware of, understand, and accept the risks and acknowledge responsibility for the consequences of my decision-making regarding the administration of anesthesia.

Signed _____ Relationship _____ Date _____

Pre-Op Physical Evaluation

To be completed by Anesthesia Provider

NPO SInce_____
SpO2 _____ HR _____ Temp _____
BP _____ RR _____
Airway Exam _____
ASA Airway Classification I II III IV
ASA Anesthesia Risk Class I II III E
Anesthesia Plan IM IV GETA
Anesthesia plan and risks discussed with patient / guardian ____

Cardiovascular _____
Respiratory _____
Hepatic / Renal _____
Neuro / Endocrine _____
GI _____
Extremities / Skin _____
Questions answered, accepted by patient / guardian _____

Comments _____
_____

Signed _____ Date _____ Time _____

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Financial Agreement and Insurance Claim Receipt

Patient Name _____ Age _____ Date of Birth _____ Gender _____
Parent/Guardian (if applicable) _____ Relationship to Patient _____
Address _____ City _____ State _____ Zip _____
Email _____ Phone _____
Does the patient have Medicaid coverage? Yes No
Does the patient have primary insurance in addition to Medicaid coverage? Yes No
Medical Insurance Company _____ ID# _____ Group # _____
Policy Holder _____ Date of Birth _____ Phone # _____

Please Read:

- Sweet Dreams, LLC does **not** process private insurance claims. Sweet Dreams does accept Medicaid coverage. Current Medicaid eligibility must be presented to anesthesia provider.
- **Payment for anesthesia is due on the date of service.** Credit card, debit card, HSA, and cash are accepted as payment. No personal checks or Care Credit will be accepted as payment
- A minimum charge of **$350** will be charged for the first hour of anesthesia.
- Anesthesia charges after the first hour will be $87.50 for each 15 minutes of anesthesia provided
- A $100 additional charge will be assessed for advanced airway management (i.e. intubation).
- Upon request, a receipt can be provided to the patient for personal insurance claim submission.
- Any delinquent payments may be sent to a collections service and assessed penalty fees.

I have read, understood, and agree to the above information:

Signed _____ Date _____

(Office use only)

CRNA _____ Office _____ Doctor _____
Address _____

Anesthesia Start _____ **Anesthesia End** _____ **Total Minutes** _____ P1 P2 P3 Reason _____
Total Charges _____ Card _____ Cash _____ Check _____ Transaction # _____

Procedure	**ICD-10 Codes**	
___Dental Restoration	___F8.40 Autism	___K00.6 Disturbance of tooth eruption
___Dental Extraction	___F84.9 Developmental Delay	___K01.81 Cracked / Fractured tooth
___Lingual / Labial Frenectomy	___K02.62 Dental caries into dentin	___K05.55 Acute periodontal disease
___Dental Implant	___K02.62 Dental caries into pulp	___K05.10 Chronic periodontal disease
___Tissue / Bone Graft	___K04.01 Reversible pulpitis	___K08.419 Loss of teeth (Trauma)
___Endodontic Treatment	___K04.02 Irreversible pulpitis	___K08.439 Loss of teeth (Caries)
___Appliance Application / Removal	___K00.4 Disturbance of tooth formation	___K04.6 Periapical abscess
___Other _____	___K00.1 Supernumerary teeth	___Z01.20 Exam / Cleaning
		___Other_____

Dental Anesthesia Billing Codes	**Units**		**Charges/Unit**		**Total Charges**	**Total Paid**
D9222 Deep IV Sedation first 15 minutes	__1__	X	$_____	=	_____	
D9223 Deep IV Sedation each 15 minutes	_____	X	$____87.50__	=	_____	
OBH17EZ Nasotracheal Intubation	_____	X	$____100____	=	_____	= $_____

Medical Billing Codes

___ 00170 Intraoral Procedure 5 units + _____ minutes / 12 = _____ time units = _____ Total Units
Signed _____ Date _____

___Matt Newbury, CRNA
___Ryan Bartholomew, CRNA
___Kendall Miller, CRNA
___Other_____

Nicole Davis, Office Manager
(801) 477-7657

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