IDAHO STATE BOARD OF DENTISTRY

PO Box 83720
Boise, ID 83720-0021

GENERAL ANESTHESIA/DEEP SEDATION PERMIT OFFICE EVALUATION FORM

EVALUATOR #1 (PLEASE PRINT):		
EVALUATOR #2 (PLEASE PRINT):		
NAME OF SEDATION PROVIDER BEING EVALUATED (PLEASE PRINT):		
SEDATION PRACTICE ADDRESS (PLEASE PRINT):		
IS SEDATION ADMINISTERED AT AN ADDITIONAL LOCATION (PLEASE PRINT): _____ **YES** _____**NO**		
ADDRESS OF SATELLITE OFFICE WHERE SEDATION IS ADMINISTERED (PLEASE PRINT):		
DATE:	**EVALUATION START TIME:**	**EVALUATION END TIME:**
_____ **INITIAL EVALUATION**	_____ **RE-EVALUATION**	_____ **SITE EVALUATION**

FACILITY, EQUIPMENT, AND DRUG REQUIREMENTS		
An operating room large enough to adequately accommodate the patient on an operating table or in an operating chair and to allow an operating team of at least two (two) individuals to freely move about the patients?	YES	NO
An operating table or chair which permits the patient to be positioned so the operating team can maintain the patient's airway, quickly alter the patient's position in an emergency, and provide a firm platform for the administration of basic life support?	YES	NO
A lighting system which permits evaluation of the patient's skin and mucosal color and a backup lighting system of sufficient intensity to permit completion of any operation underway in the event of a general power failure?	YES	NO
Suction equipment which permits aspiration of the oral and pharyngeal cavities and a backup suction device which will function in the event of a general power failure?	YES	NO
An oxygen delivery system with adequate full face mask and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate backup system?	YES	NO
A recovery area that has available oxygen, adequate lighting, suction and electrical outlets? (The recovery area can be the operating room)	YES	NO
A sphygmomanometer, precordial/pretracheal stethoscope, end-tidal carbon dioxide monitor, pulse oximeter, oral and nasopharyngeal airways, supraglottic airway devices, intravenous fluid administration equipment, and automated external defibrillator (AED)?	YES	NO
Emergency drugs including, but not limited to, pharmacologic antagonists appropriate to the drugs used, vasopressors, bronchodilators, antihistamines, and anticonvulsants?	YES	NO

OVERALL FACILITY, EQUPMENT, AND DRUG REQUIREMENTS? _____ Adequate _____ Inadequate

PERSONNEL (Please provide a copy of each to the evaluator)		
ACLS/PALS Certification of Sedation Provider?	YES	NO
Assistant and/or Auxiliary personnel Basic Life Support for Healthcare Providers Certification?	YES	NO

OVERALL PERSONNEL? _____ Adequate _____ Inadequate

RECORDS (Please provide a copy of each to the evaluator)		
Medical History Form (which should include ASA Patient Physical Status Classifications)	YES	NO
Preoperative Instructions	YES	NO
Sedation Consent Form	YES	NO
Postoperative Instructions	YES	NO

OVERALL RECORDS? _____ Adequate _____ Inadequate

SIMULATED EMERGENCIES – The DDS/DMD and his/her clinical team must indicate competency (by demonstration or discussion) in treating the following emergencies.		
Laryngospasm	_____ Satisfactory	_____ Unsatisfactory
Bronchospasm and Airway Obstruction	_____ Satisfactory	_____ Unsatisfactory
Emesis and Aspiration	_____ Satisfactory	_____ Unsatisfactory
Angina Pectoris	_____ Satisfactory	_____ Unsatisfactory
Myocardial Infarction	_____ Satisfactory	_____ Unsatisfactory
Cardiac Arrest	_____ Satisfactory	_____ Unsatisfactory
Hypotension	_____ Satisfactory	_____ Unsatisfactory
Hypertension	_____ Satisfactory	_____ Unsatisfactory
Acute Allergic Reaction	_____ Satisfactory	_____ Unsatisfactory
Syncope, Loss of Consciousness	_____ Satisfactory	_____ Unsatisfactory
Hyperventilation	_____ Satisfactory	_____ Unsatisfactory
Convulsions	_____ Satisfactory	_____ Unsatisfactory

OBSERVATION OF A SEDATION CASE	
_____ Satisfactory	_____ Unsatisfactory

DOCUMENTATION (Sedation Patient Records) – FOR RE-EVALUATIONS ONLY (Please make available to the evaluators three (3) random records of patients for whom sedation services were provided.)		
Blood pressure, heart rate, and respiration were recorded every five (5) minutes during sedation?	YES	NO
Preoperative and postoperative vital signs?	YES	NO
Medications administered with dosages, time intervals, and route of administration?	YES	NO
Discharge entry indicating patient's condition upon discharge and the name of the responsible party to whom the patient was discharged?	YES	NO
Sedation Case Log/Drug Log	YES	NO

OVERALL DOCUMENTATION? _____ Adequate _____ Inadequate

DEFICIENCIES NOTED/CORRECTIVE ACTION RECOMMENDATIONS

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*Based on the overall results of this evaluation, the Board of Dentistry will make a determination as to whether or not corrective action should be taken. Corrective action may include a follow-up evaluation, written follow-up, etc. The Board will notify the sedation permit holder with details of the corrective action. A sedation permit will not be issued until ALL requirements of the evaluation are satisfied.

_____

Signature of Permit Holder

_____

Signature of Evaluator #1

_____

Signature of Evaluator #2

PATIENT CONSENT FORM

I, the undersigned, am a patient of _____ (hereinafter "dentist/dental specialist"). My dentist/dental specialist has explained to me that a periodic evaluation is required in connection with the anesthesia permit issued to him/her by the Idaho State Board of Dentistry ("Board of Dentistry"). The Board of Dentistry is required to routinely conduct evaluations of all the anesthesia permit holders in Idaho. My dentist/dental specialist has further explained to me that it is necessary for one (1) or more Idaho State Board of Dentistry evaluators to personally observe the treatment provided to a patient. The evaluators are also dentists/dental specialists who are anesthesia permits holders in Idaho. My dentist/dental specialist has requested my consent to allow the Board of Dentistry's evaluators to observe the treatment provided to me. Although my dentist/dental specialist may discuss my treatment with the evaluators and that the evaluators may discuss my treatment between themselves, I understand that the evaluators will treat any of the information they receive during their evaluation as confidential. Therefore, I hereby freely, knowingly and voluntarily consent to and authorize the Board of Dentistry's evaluators to observe the treatment provided to me by my dentist/dental specialist. This consent shall be in full force and effect for a period of fourteen (14) days from the date of its execution, at which time it will expire.

_____
Patient Signature

_____
Date