OFFICE ANESTHESIA EVALUATION

Illinois Society of Oral and Maxillofacial Surgeons

Name(s) of member(s) evaluated: Only **MEMBERS and APPLICANTS** for membership may participate.

Address where this evaluation took place:

Street

ZIP

City

Phone

Evaluator

Date

IMPORTANT: *Enclose a copy of the Illinois Dental Sedation Permit showing the permit number and the expiration date for each member evaluated.*

Instructions

- Prior to evaluation, review criteria and guidelines from current AAOMS Anesthesia Manual.
- Answer all questions by checking "Yes" or “No", "Satisfactory" or "Needs Improvement", where applicable.
- Sign completed Evaluation Form and return it to ISOMS. A copy should be left with the applicant or member who has been evaluated. Co evaluation forms are scanned and retained in ISOMS electronic files.
- Narrative explanations should be completed in detail if an applicant or member is deficient with any portion of the evaluation. Any defici must be corrected promptly in accordance with ISOMS policies. **The evaluator is responsible for follow-up on any noted deficiencies, inc notification to ISOMS.** Use an extra sheet of paper if needed.

Effective April 1, 2016, an assistant who has completed the 12 hours of training required by the State of Illinois, and o assistant are required to be present during the evaluation. It is recommended that clerical staff be present as well.

Were **two assistants** present for the evaluation? ☐ Yes

Does this practice discuss and undergo mock emergency simulations with staff 2 times/annually? ☐ Yes

OFFICE FACILITIES & EQUIPMENT

Capnography Monitoring Equipment

Required per AAOMS Parameters of Care: Clinical Practice Guidelines for Oral and Maxillofacial Surgery (AAOMS ParCare 2012) as of January 2014

Is capnography equipment available? ☐ Yes

Operating Theater

Large enough to adequately accommodate the patient on operating chair (table)? ☐ Yes

Large enough to permit operating team of three individuals to freely move? ☐ Yes

Operating Chair or Table

DATE ___________________________

Will permit patient positioning so that team can maintain airway? ☐ Yes
Will permit rapid patient positioning in an emergency? ☐ Yes
Will provide firm platform for management of CPR? ☐ Yes

Lighting System

Permits adequate evaluation of patient's skin and mucosal color? ☐ Yes
Back-up battery system available? ☐ Yes
Back-up system of adequate intensity to complete surgery in case of power failure? ☐ Yes

Oxygen Delivery System

Adequate full face masks and appropriate connectors available? ☐ Yes
Is a laryngeal mask airway available? ☐ Yes
Can it deliver positive pressure oxygen to the patient? ☐ Yes
Is a separate back-up system available? ☐ Yes
Is a noninvasive blood pressure monitor available? ☐ Yes

Suction Equipment

Adequate full face masks and appropriate connectors available? ☐ Yes
Back-up suction (independent of electrical supply) available? ☐ Yes

Recovery Area *Recovery area can be the operating theater*

Is oxygen available? ☐ Yes
Is adequate suction available? ☐ Yes
Is lighting adequate? ☐ Yes
Are there adequate electrical outlets? ☐ Yes
Adequate full face masks and appropriate connectors available? ☐ Yes

Ancillary Equipment

Working laryngoscope with selection of blades, spare batteries & bulbs? ☐ Yes
Endotracheal tubes with appropriate connectors? ☐ Yes
Oral Airways? ☐ Yes
Tonsilar suction or pharyngeal type suction tip adaptable to office suctions? ☐ Yes
Endotracheal tube forceps? ☐ Yes
Sphygmomanometer and stethoscope? ☐ Yes
Electrocardiogram? ☐ Yes
Defibrillator? ☐ Yes
Adequate equipment to establish an intravenous infusion? ☐ Yes
Pulse oximeter? ☐ Yes

PATIENT RECORDS

DATE ___________________________

OFFICE ANESTHESIA EVALUATION

Illinois Society of Oral and Maxillofacial Surgeons

Item	
Adequate medical history?	☐ Yes
Adequate physician evaluation?	☐ Yes
Anesthesia records every 5 minutes showing blood pressure?	☐ Yes
Anesthesia records showing pulse oximetry readings?	☐ Yes
Anesthesia records showing the drugs and amounts used?	☐ Yes
Anesthesia records reflecting the length of the procedure?	☐ Yes
Anesthesia records reflecting any complications of anesthesia?	☐ Yes
Evidence of continuous recovery monitoring, with notation of patient's condition upon discharge and person to whom the patient was discharged?	☐ Yes

EMERGENCY DRUGS

Drug		
Vasopressor	☐ Yes	☐ No
Corticosteroid	☐ Yes	☐ No
Bronchodilator	☐ Yes	☐ No
Muscle Relaxant	☐ Yes	☐ No
Narcotic Antagonist	☐ Yes	☐ No
Antiarrythmic	☐ Yes	☐ No
Antihistaminic	☐ Yes	☐ No

Drug	
Benzodiazepine Antagonist	☐ Yes
Anticholinergic	☐ Yes
Coronary Artery Vasodilator	☐ Yes
Anithypertensive	☐ Yes
Anticonvulsant	☐ Yes
Intravenous Medication for Treatment of Cardiac Arrest	☐ Yes

SIMULATED EMERGENCIES Discussion and/or Demonstration

Emergency		
Laryngospasm	☐ Satisfactory	☐ Needs Ir
Bronchospasm	☐ Satisfactory	Improvem
Emesis & Aspiration of foreign material under anesthesia	☐ Satisfactory	Improvem
Management of foreign body in airway	☐ Satisfactory	Improvem
Angina Pectoris/Myocardial Infarction	☐ Satisfactory	Improvem
Hypotension	☐ Satisfactory	Improvem
Hypertension	☐ Satisfactory	Improvem
Cardiac Arrest	☐ Satisfactory	Improvem
Acute Allergic Reaction	☐ Satisfactory	Improvem
Seizure	☐ Satisfactory	Improvem
Hyperventilation Syndrome	☐ Satisfactory	Improvem
Syncope	☐ Satisfactory	Improvem
Malignant Hyperthermia	☐ Satisfactory	Improvem
Venipuncture Complication(s)	☐ Satisfactory	Improvem

Statement of Applicant or Member(s) Being Evaluated

I hereby confirm that all OTHER LOCATIONS (or, satellite offices) at which I (we) perform general anesthesia or conscious sedatior equipped to the standards of the office at which this evaluation has been conducted with respect to facility, equipment and perso

DATE ___________________________

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Signature ______ **Date** ______

Anesthesia Committee Members' Narrative Comments: Attach an extra sheet if necessary, to explain any discrepancies or to clari Improvement" answers. All "no" answers must be accounted for with an explanation as to how they will be rectified, or when missing supplies or equipment will be secured. Completed evaluation dates will not be reported to AAOMS until all questions are and explanations are provided for any missing elements of this evaluation.

NOTE: ISOMS requires a copy of:

(1) the doctor's Illinois Anesthesia Permit,

(2) the doctor's current Advanced Cardiac Life Support (ACLS) training card, and

(3) proof that at least one anesthesia/office assistant who assists the doctor during anesthesia has completed the 12 hours of tra required by the State of Illinois. A copy of a letter or a dated certificate of course completion will suffice.

SEND BY FAX TO 847-574-0445

Signature of ISOMS Member(s) or Applicant for membership who has bee evaluated:

Signature ______ **Date** ______

Print Name ______ Email ______

Illinois Dental License # ______ Illinois Dental Sedation Permit # ______

Signature ______ **Date** ______

Print Name ______ Email ______

Illinois Dental License # ______ Illinois Dental Sedation Permit # ______

Signature ______ **Date** ______

Print Name ______ Email ______

Illinois Dental License # ______ Illinois Dental Sedation Permit # ______

Signature of the Evaluator, a member of the ISOMS Anesthesia Committee:

Signature ______ **Date** ______

Print Name ______ Email ______

DATE ____________________________

OFFICE ANESTHESIA EVALUATION

Illinois Society of Oral and Maxillofacial Surgeons

Illinois Dental License #		Illinois Dental Sedation Permit #	

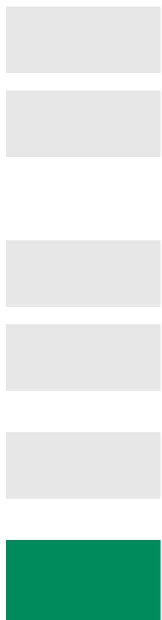
Please mail or fax this signed form when completed, with the required documents:
• A copy of the doctor's current Illinois Dental Anesthesia Permit
• Proof of current ACLS certification
• Proof that at least one anesthesia assistant has completed 12 hours of training as required by the State of Illinois

12.21.2021

Please return completed form electronically, by fax or email for easier storage. Thank you!

Illinois Society of Oral & Maxillofacial Surgeons
Tel. 847-482-0222 • Fax 847-574-0445
IllinoisOMS@gmail.com • isoms.net
Jane Stein, Executive Director • 847-508-3343

DATE ___________________________



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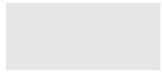

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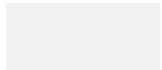

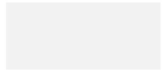

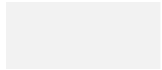

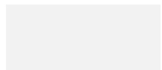

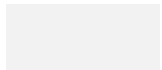

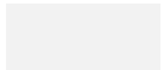

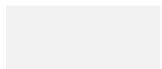

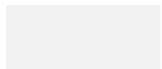

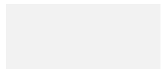

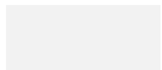

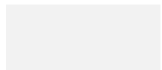

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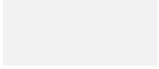

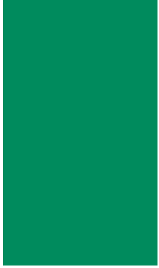

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