



Georgia Society of Oral and Maxillofacial Surgeons

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Anesthesia On-Site Inspection and Evaluation Form

Date Sent to Society _____

Name of Practitioner Evaluated _____

General Anesthesia Permit Number (if applicable) _____ Dental License # _____

Location Inspected _____

Telephone Number _____

Date of Evaluation _____ Time of Evaluation _____

Names of Evaluators _____

A. PERSONNEL

1. ACLS Certificate (Please have doctor's ACLS Certification available) _____

2. PALS Certificate (if appropriate) _____

3. Evidence of: 1 year advanced training in anesthesiology, Fellow of the American Dental Society of Anesthesiology, Diplomate of the National Dental Board of Anesthesiology, Diplomate of the American Board of Oral and Maxillofacial Surgery, eligible for examination by American Board of Oral and Maxillofacial Surgery, or Fellow of the American Association of Oral and Maxillofacial Surgeons.

4. List of assisting staff's credentials/CV/training: (ie: dental assistant, surgical tech, RN, etc) and training (ie: AAOMS anesthesia assisting certified, ACLS, etc):

a. _____

b. _____

c. _____

d. _____

B. RECORDS

Have available three charts of patients who have been treated in your office with intravenous sedation or general anesthesia.

1. An adequate medical history of the patient. Yes _____ No _____

2. An adequate physical evaluation of the patient. Yes _____ No _____

3. Anesthesia records showing: continuous monitoring of heart rate, blood pressure, and respiration using electrocardiographic monitoring and pulse oximetry. Yes _____ No _____

4. Recording of monitoring every 5 minutes. Yes _____ No _____

5. Evidence of continuous recovery monitoring, with notation of patient's condition upon discharge and person to whom the patient was discharged. Yes _____ No _____

6. Accurate recording of medications administered, including amounts and time administered. Yes _____ No _____

7. Records illustrating length of procedure. Yes _____ No _____

8. Records reflecting any complications of anesthesia. Yes _____ No _____

C. OFFICE FACILITY AND EQUIPMENT

1. Noninvasive Blood Pressure Monitor Yes _____ No _____

2. Electrocardiograph Yes _____ No _____

3. Defibrillator/Automated External Defibrillator Yes _____ No _____

4. Pulse Oximeter Yes _____ No _____

5. Operating Theater

a. Is the operating theater large enough to accommodate the patient on a table or in an operating chair adequately? Yes _____ No _____

b. Does the operating theater permit an operating team consisting of at least three individuals to move freely about the patient? Yes _____ No _____

6. Operating Chair or Table

a. Does the operating chair or table permit the patient to be positioned so the operating team can maintain the airway? . Yes _____ No _____

b. Does the operating chair or table permit the team to alter the patient's position quickly in an emergency? Yes _____ No _____

c. Does the operating chair or table provide a firm platform for the management of cardiopulmonary resuscitation? Yes _____ No _____

7. Lighting System Yes _____ No _____

a. Does the lighting system permit evaluation of the patient's skin and mucosal color? Yes _____ No _____

b. Is there a battery-powered backup lighting system? Yes _____ No _____

b. Is the backup lighting system of sufficient intensity to permit completion of any operation underway at the time of general power failure? Yes _____ No _____

8. Suction Equipment Yes_____ No_____
- a. Does the suction equipment permit aspiration of the oral and pharyngeal cavities? Yes_____ No_____
- b. Is there a backup suction device available? Yes_____ No_____
9. Oxygen Delivery System Yes_____ No_____
- a. Does the oxygen delivery system have adequate full-face masks and appropriate connectors, and is it capable of delivering oxygen to the patient under positive pressure? Yes_____ No_____
- b. Is there an adequate backup oxygen delivery system? Yes_____ No_____
10. Recovery Area (recovery area can be the operating theater) Yes_____ No_____
- a. Does the recovery area have available oxygen? Yes_____ No_____
- b. Does the recovery area have available adequate suction? Yes_____ No_____
- c. Does the recovery area have adequate lighting? Yes_____ No_____
- d. Does the recovery area have adequate electrical outlets? Yes_____ No_____
- e. Can the patient be observed by a member of the staff at all times during the recovery period? Yes_____ No_____
11. Ancillary Equipment
- a. Is there a working laryngoscope complete with an adequate selection of blades, spare batteries, and bulbs? Yes_____ No_____
- b. Are there endotracheal tubes and appropriate connectors? Yes_____ No_____
- c. Are there oral airways? Yes_____ No_____
- d. Are there any laryngeal mask airways? Yes_____ No_____
- e. Is there a tonsillar or pharyngeal type suction tip adaptable to all office outlets? Yes_____ No_____
- f. Are there endotracheal tube forceps? Yes_____ No_____
- g. Is there a sphygmomanometer and stethoscope? Yes_____ No_____
- h. Are there an electrocardioscope and defibrillator/automated external defibrillator? Yes_____ No_____
- i. Is there a pulse oximeter? Yes_____ No_____
- j. Is there adequate equipment for the establishment of an intravenous infusion? Yes_____ No_____

D. DRUGS

1. Vasopressor drug available? Yes_____ No_____

- 2. Corticosteroid drug available? Yes_____ No_____
- 3. Bronchodilator drug available? Yes_____ No_____
- 4. Muscle relaxant drug available? Yes_____ No_____
- 5. Intravenous medication for treatment of cardiopulmonary arrest available? Yes_____ No_____
- 6. Narcotic antagonist drug available? Yes_____ No_____
- 7. Benzodiazepine antagonist drug available? Yes_____ No_____
- 8. Antihistamine drug available? Yes_____ No_____
- 9. Antiarrhythmic drug available? Yes_____ No_____
- 10. Anticholinergic drug available? Yes_____ No_____
- 11. Coronary artery vasodilator drug available? Yes_____ No_____
- 12. Antihypertensive drug available? Yes_____ No_____
- 13. Mechanism of response for malignant hyperthermia (dantrolene)? Yes_____ No_____

OVERALL EQUIPMENT - FACILITY _____ ADEQUATE _____ INADEQUATE

COMMENTS: _____

RECOMMENDATIONS:

Signature(s) of Evaluators: _____

Printed Name(s) of Evaluators: _____
