OFFICE ANESTHESIA EVALUATION
Illinois Society of Oral and Maxillofacial Surgeons.

Date ______________________

Name(s) of member(s) evaluated:
________________________________________________________________________
________________________________________________________________________

Address Where This Evaluation Took Place:
________________________________________________________________________

City ___________________________ Zip __________  Phone _____________________

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

Evaluator _______________________________________________________________

Instructions:
• Prior to evaluation, review criteria and guidelines from current AAOMS Anesthesia Manual.
• Answer all questions by circling “Y” for Yes, or “N” for 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. Completed 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 deficiencies must be corrected promptly in accordance with ISOMS
    policies. The evaluator is responsible for follow up on any noted deficiencies, including 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 one other assistant are required to be present during the evaluation. It is recommended that clerical staff be
present as well.

Check here to indicate that two assistants were present for the evaluation. ______Yes

A. OFFICE FACILITIES and EQUIPMENT

Capnography Monitoring Equipment (required per AAOMS Parameters of Care: Clinical Practice
Is capnography equipment available? Y N

Operating Theater
Large enough to adequately accommodate the patient on operating chair (table)? Y N
Large enough to permit operating team of three individuals to freely move? Y N

Operating Chair or Table
Will permit patient positioning so that team can maintain airway? Y N
Will permit rapid patient positioning in an emergency? Y N
Will provide firm platform for management of CPR? Y N

Lighting System
Permits adequate evaluation of patient’s skin and mucosal color? Y N
Back-up battery system available? Y N
Back-up system of adequate intensity to complete surgery in case of power failure? Y N
Oxygen Delivery System
- Adequate full face masks and appropriate connectors available? Y N
- Is a laryngeal mask airway available? Y N
- Can it deliver positive pressure oxygen to the patient? Y N
- Is a separate back-up system available? Y N
- Is a noninvasive blood pressure monitor available? Y N

Suction Equipment
- Permits aspiration of the oral and pharyngeal cavities? Y N
- Back-up suction (independent of electrical supply) available? Y N

Recovery Area (Recovery area can be the operating theater)
- Is oxygen available? Y N
- Is adequate suction available? Y N
- Is lighting adequate? Y N
- Are there adequate electrical outlets? Y N
- Can patient be observed by staff at all times during recovery period? Y N

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

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

C. EMERGENCY DRUGS
- Vasopressor Y N
- Corticosteroid Y N
- Bronchodilator Y N
- Muscle Relaxant Y N
- Narcotic Antagonist Y N
- Benzodiazepine Antagonist Y N
- Antihistaminic Y N
- Antiarrythmic Y N
- Anticholinergic Y N
- Coronary Artery Vasodilator Y N
- Anti hypertensive Y N
- Anticonvulsant Y N
- Intravenous Medication for Treatment of Cardiac Arrest Y N
### D. SIMULATED EMERGENCIES – Discussion and/or Demonstration

<table>
<thead>
<tr>
<th>Condition</th>
<th>Satisfactory</th>
<th>Needs Improvement</th>
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<tbody>
<tr>
<td>1. Laryngospasm</td>
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<tr>
<td>2. Bronchospasm</td>
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<td>3. Emesis &amp; Aspiration of foreign material under anesthesia</td>
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<td>4. Management of Foreign Body in Airway</td>
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<td>5. Angina Pectoris/Myocardial Infarction</td>
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<td>6. Hypotension</td>
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<td>7. Hypertension</td>
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<td>8. Cardiac Arrest</td>
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<td>9. Acute Allergic Reaction</td>
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<td>10. Seizure</td>
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<td>11. Hyperventilation Syndrome</td>
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<td>12. Syncope</td>
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<td>13. Malignant Hyperthermia</td>
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<td>14. Venipuncture Complication(s)</td>
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**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 sedation are equipped to the standards of the office at which this evaluation has been conducted with respect to facility, equipment and personnel.

Signature ___________________________ Date __________________

Anesthesia Committee Members’ Narrative Comments: Attach an extra sheet if necessary, to explain any discrepancies or to clarify any "Needs 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 answered 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 training as 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 been evaluated:
(More than one doctor may sign this sheet, if applicable. Make a copy for larger groups.)

Signature (1) __________________________________________ Date _________________
Printed Name _________________________________________________
EMAIL ________________________________________________________

Signature (2) __________________________________________ Date _________________
Printed Name _________________________________________________
EMAIL ________________________________________________________

Signature (3) __________________________________________ Date _________________
Printed Name _________________________________________________
EMAIL ________________________________________________________

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

Signature __________________________________________ Date _________________
Printed Name _________________________________________________
EMAIL ________________________________________________________

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.

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

Illinois Society of Oral & Maxillofacial Surgeons
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