OFFICE ANESTHESIA EVALUATION

Date ________________________________

You may copy this form when evaluating multiple doctors at one time.

Name(s) of members evaluated: ____________________________________________________________

Address Where 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 Guidelines for Oral and Maxillofacial Surgery (AAOMS ParCare 2012) as of Jan. 2014.

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 five 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

<table>
<thead>
<tr>
<th>Drug</th>
<th>Y</th>
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<tbody>
<tr>
<td>Vasopressor</td>
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<td>Corticosteroid</td>
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<td>Bronchodilator</td>
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<td>Muscle Relaxant</td>
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<td>Narcotic Antagonist</td>
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<td>Benzodiazepine Antagonist</td>
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<td>Antihistaminic</td>
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<td>Coronary Artery Vasodilator</td>
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<td>Anticonvulsant</td>
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<td>Intravenous Medication for</td>
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<tr>
<td>Treatment of Cardiac Arrest</td>
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D. SIMULATED EMERGENCIES – Discussion and/or Demonstration

1. Laryngospasm  _____ Satisfactory  _____ Needs Improvement
2. Bronchospasm  _____ Satisfactory  _____ Needs Improvement
3. Emesis & Aspiration of foreign material under anesthesia  _____ Satisfactory  _____ Needs Improvement
4. Management of Foreign Body in Airway  _____ Satisfactory  _____ Needs Improvement
5. Angina Pectoris/Myocardial Infarction  _____ Satisfactory  _____ Needs Improvement
6. Hypotension  _____ Satisfactory  _____ Needs Improvement
7. Hypertension  _____ Satisfactory  _____ Needs Improvement
8. Cardiac Arrest  _____ Satisfactory  _____ Needs Improvement
9. Acute Allergic Reaction  _____ Satisfactory  _____ Needs Improvement
10. Seizure  _____ Satisfactory  _____ Needs Improvement
11. Hyperventilation Syndrome  _____ Satisfactory  _____ Needs Improvement
12. Syncope  _____ Satisfactory  _____ Needs Improvement
13. Malignant Hyperthermia  _____ Satisfactory  _____ Needs Improvement
14. Venipuncture Complication(s)  _____ Satisfactory  _____ Needs Improvement

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:
______________________________________________________________
______________________________________________________________
______________________________________________________________

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.
Signature of ISOMS Member 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 Illinois 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!
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