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

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

#### 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:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

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**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.

To help assure safe delivery, please use this address when mailing evaluations:
Illinois Society of Oral & Maxillofacial Surgeons
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Email: isoms99@aol.com