STATE OF RHODE ISLAND  
CENTER FOR PROFESSIONAL BOARDS AND COMMISSIONS  
BOARD OF EXAMINERS IN DENTISTRY  

DENTAL FACILITY ANESTHESIA PERMIT  
MODERATE SEDATION OFFICE EVALUATION FORM  

***This form must be completed by site inspector(s) only. Inspector(s) must indicate “NA” if not applicable***

<table>
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<tr>
<th>NAME OF PRACTITIONER:</th>
<th>INDIVIDUAL ANESTHESIA PERMIT #:</th>
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LOCATION INSPECTED:

NAME OF FACILITY

STREET | CITY/TOWN/STATE | ZIP

PRACTITIONER CONTACT INFORMATION:

________________________ / ____________________ / ____________________

TELEPHONE | FAX | E-MAIL

DATE OF EVALUATION: _____/_____/___________

A. PRACTITIONER INFORMATION:

1. BCLS Certificate  Yes______ No_____ Expiration date____/____/_____

2. ACLS Certificate  Yes______ No_____ Expiration date____/____/_____

3. PALS Certificate  Yes______ No_____ Expiration date____/____/_____

4. Yearly OSHA training  
   Course date____/____/_____
   Yes______ No______

5. Insurance coverage for office sedation  Yes______ No______

6. Hospital affiliations:

   ___________________________________________________________________
   ___________________________________________________________________

7. On call 24 hour coverage  Yes______ No______
B. **ASSISTANTS INFORMATION:** (additional forms available as needed)

*Minimum of one clinical staff and one office staff member present during sedation*

1) **NAME:**

_________________________________________________________

**DAANCE Certified:**

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2) **NAME:**

_________________________________________________________

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C. **REQUIRED EQUIPMENT:**

*If the practice is a multiple doctor facility, redundant equipment to handle simultaneous procedures/emergencies is REQUIRED*

1. Noninvasive blood pressure monitor
   
   Yes_____ No______

2. Electrocardiograph with the ability to print tracing
   
   Yes_____ No______

3. Defibrillator/Automated External Defibrillator/pacer with battery back-up
   
   Yes_____ No______

4. Pulse oximeter
   
   Yes_____ No______

5. End-tidal carbon dioxide monitor (suggested)
   
   Yes_____ No______

6. Equipment maintained and inspected
   
   Yes_____ No______

7. Operating Theater:
   
   a. Is the operating theater easily accessible to emergency personnel and their equipment?
      
      Yes_____ No______
b. Is the operating theater large enough to adequately accommodate the patient on a table or in an operating chair?
   Yes______ No______

c. Does the operating theater permit an operating team consisting of at least three (3) individuals to move freely about the patient?
   Yes______ No______

8. Operating Chair or Table:

   a. Does the operating chair or table permit the patient to be positioned so the operating team can adequately 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______

9. Lighting System:

   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______

   c. Is the backup lighting system of sufficient intensity to permit completion of any operation underway at the time of general power failure?
      Yes______ No______

10. Suction Equipment:

    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______

    c. Is there suction equipment for use during a power failure?
       Yes______ No______

    d. Is there capability to suction in all operatories and recovery rooms?
       Yes______ No______

11. Oxygen Delivery System:

    a. Does the oxygen delivery system have adequate, clear face masks with appropriate connectors and sizes for adults and children, and is it capable of delivering oxygen to the patient under positive pressure?
       Yes______ No______

    b. Is there an adequate backup oxygen delivery system in the event of a power failure?
       *Minimum of four (4) E size oxygen tanks on site
       Yes______ No______
12. Recovery Area/Discharge Room:

*Recovery area can be the operating theater*

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 recovery period?
   Yes______  No______

f. Does the recovery area/discharge room provide adequate room to address a medical emergency if necessary?
   Yes______  No______

13. Required Airway 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 the office outlets?
   Yes______  No______

f. Is there an AED or defibrillator/Pacer with 6 second tape?
   Yes______  No______

g. Are there endotracheal tube forceps?
   Yes______  No______

h. Is there a sphygmomanometer and stethoscope?
   Yes______  No______

i. Are there electrocardiograph and defibrillator/automated external defibrillator?
   Yes______  No______

j. Is there a pulse oximeter?
   Yes______  No______

k. Is there adequate equipment for the establishment of an intravenous infusion?
   Yes______  No______
l. Is there a scavenger system if inhalation agents are used?
   Yes______  No______

m. Is there a means to monitor temperature?
   Yes______  No______

n. Are there IV fluids and tubing, catheters, and arm boards?
   Yes______  No______

o. Is there quicktrach or other method for surgical airway?
   Yes______  No______

What is the emergency plan, including the role of staff members, should there be a significant anesthesia emergency at the facility?
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

D. **REQUIRED DRUGS:**

1. Oxygen – continuous use during general anesthesia and/or parenteral sedation
   Yes______  No______

2. Epinephrine: 1:10,000 and 1:1,000
   Yes______  No______

3. Atropine
   Yes______  No______

4. Lidocaine for arrhythmias
   Yes______  No______

5. Adenosine or Verapamil
   Yes______  No______

6. Antihistamine Diphenhydramine
   Yes______  No______

7. Anticonvulsant (e.g. Valium, Pentobarbital) Versed
   Yes______  No______

8. Coronary vasodilator (e.g. Nitroglycerine)
   Yes______  No______

9. IV Antihypoglycemic agent (Glucose) Dextrose 50% or Glucagon
   Yes______  No______

10. Steroid (Solucortef)
    Yes______  No______

11. Aerosol Nebulizer (Albuterol B2 agonist) with connector to airway circuitry
    Yes______  No______

12. Vasopressor (e.g. Phenylephrine, Dopamine, Norepinephrine, Ephedrine)
    Yes______  No______
13. Narcotic (e.g. Demerol, Morphine, Sublimaze)  
   Yes______  No______

14. Narcotic antagonist, if narcotics are used (Narcan)  
   Yes______  No______

15. Antagonist, if Benzodiazepines are used (Romazicon)  
   Yes______  No______

16. Succinylcholine  
   Yes______  No______

17. Anti-hypertensive medications (e.g., Ca channel blocker, beta blocker, sodium nitroprusside)  
   Yes______  No______

18. Dantrolene Sodium – required if a halogenated anesthetic agent (e.g. Halothane, Enflurane, Isoflurane) is used. It is also required if depolarizing skeletal muscle relaxants (e.g. Succinylcholine) are routinely administered, as in intubation.  
   Yes______  No______

19. Antiemetic or Zofran  
   Yes______  No______

20. Aspirin (ASA)  
   Yes______  No______

21. Lasix  
   Yes______  No______

22. Magnesium Sulfate  
   Yes______  No______

E. DRUG MANAGEMENT:

1. Sterile techniques  
   Yes______  No______

2. Labelings  
   Yes______  No______

3. Inventory control  
   Yes______  No______

4. Medication refrigerator with thermometer and alarm  
   Yes______  No______

5. Daily Temperature Log on refrigerator  
   Yes______  No______

F. POST-OPERATIVE MONITORING:

1. Transport  
   Yes______  No______

2. Instructions  
   Yes______  No______

3. Discharge criteria and documentation  
   Yes______  No______
OVERALL EQUIPMENT/FACILITY:

_____ADEQUATE       _____INADEQUATE

COMMENTS/RECOMMENDATIONS:

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

SIGNATURE OF EVALUATORS       PRINTED NAME OF EVALUATORS

1.___________________________________       ________________________________

2.___________________________________       ________________________________

3.___________________________________       ________________________________

*****************************************************************************

I, __________________________________________, acknowledge that I have received a completed
(copy of this Moderate Sedation Office Evaluation Form.

PRACTITIONER SIGNATURE       DATE