

IDAHO STATE BOARD OF DENTISTRY

PO Box 83720
Boise, ID 83720-0021

MODERATE SEDATION PERMIT OFFICE EVALUATION FORM

NAME OF SEDATION PROVIDER BEING EVALUATED (PLEASE PRINT):		
SEDATION PRACTICE ADDRESS (PLEASE PRINT):		
IS SEDATION REGULARLY ADMINISTERED AT AN ADDITIONAL LOCATION (PLEASE PRINT): <p align="center">_____ YES _____ NO</p>		
ADDRESS OF SATELLITE OFFICE WHERE SEDATION IS REGULARLY ADMINISTERED (PLEASE PRINT):		
_____ MODERATE ENTERAL PERMIT	_____ MODERATE PARENTERAL PERMIT	
DATE:	EVALUATION START TIME:	EVALUATION END TIME:
_____ INITIAL EVALUATION	_____ RE-EVALUATION	
EVALUATOR #1 (PLEASE PRINT):		
EVALUATOR #2 (PLEASE PRINT):		

FACILITY, EQUIPMENT, AND DRUG REQUIREMENTS		
An operating room large enough to adequately accommodate the patient on an operating table or in an operating chair and to allow an operating team of at least two (two) individuals to freely move about the patients?	YES	NO
An operating table or chair which permits the patient to be positioned so the operating team can maintain the patient's airway, quickly alter the patient's position in an emergency, and provide a firm platform for the administration of basic life support?	YES	NO
A lighting system which permits evaluation of the patient's skin and mucosal color and a backup lighting system of sufficient intensity to permit completion of any operation underway in the event of a general power failure?	YES	NO
Suction equipment which permits aspiration of the oral and pharyngeal cavities and a backup suction device which will function in the event of a general power failure?	YES	NO
An oxygen delivery system with adequate full face mask and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate backup system?	YES	NO
A recovery area that has available oxygen, adequate lighting, suction and electrical outlets? (The recovery area can be the operating room)	YES	NO
A sphygmomanometer, pulse oximeter, oral and nasopharyngeal airways, supraglottic airway devices, and automated external defibrillator (AED)?	YES	NO
Emergency drugs including, but not limited to, pharmacologic antagonists appropriate to the drugs used, bronchodilators, and antihistamines?	YES	NO
FOR MODERATE PARENTERAL ONLY – Precordial/pretracheal stethoscope or end-tidal carbon dioxide monitor, intravenous fluid administration equipment, vasopressors, and anticonvulsants?	YES	NO

OVERALL FACILITY, EQUIPMENT, AND DRUG REQUIREMENTS? _____ Adequate _____ Inadequate

PERSONNEL (Please provide a copy of each to the evaluator)		
ACLS/PALS Certification of Sedation Provider? (For re-evaluations only)	YES	NO
Assistant and/or Auxiliary personnel Basic Life Support for Healthcare Providers Certification?	YES	NO
Documentation of periodic reviews of office emergency protocol, including simulated exercises, to assure proper equipment function and staff interaction?	YES	NO

OVERALL PERSONNEL? _____ Adequate _____ Inadequate

RECORDS (Please provide a copy of each to the evaluator)		
Medical History Form (which should include ASA Patient Physical Status Classifications)	YES	NO
Preoperative Instructions	YES	NO
Sedation Consent Form	YES	NO
Postoperative Instructions	YES	NO

OVERALL RECORDS? _____ Adequate _____ Inadequate

SIMULATED EMERGENCIES – The DDS/DMD and his/her clinical team must indicate competency (by demonstration or discussion) in treating the following emergencies.		
Laryngospasm	_____ Satisfactory	_____ Unsatisfactory
Bronchospasm and Airway Obstruction	_____ Satisfactory	_____ Unsatisfactory
Emesis and Aspiration	_____ Satisfactory	_____ Unsatisfactory
Angina Pectoris	_____ Satisfactory	_____ Unsatisfactory
Myocardial Infarction	_____ Satisfactory	_____ Unsatisfactory
Cardiac Arrest	_____ Satisfactory	_____ Unsatisfactory
Hypotension	_____ Satisfactory	_____ Unsatisfactory
Hypertension	_____ Satisfactory	_____ Unsatisfactory
Acute Allergic Reaction	_____ Satisfactory	_____ Unsatisfactory
Syncope, Loss of Consciousness	_____ Satisfactory	_____ Unsatisfactory
Hyperventilation	_____ Satisfactory	_____ Unsatisfactory
Convulsions	_____ Satisfactory	_____ Unsatisfactory

PATIENT CONSENT FORM

I, the undersigned, am a patient of _____ (hereinafter “dentist/dental specialist”). My dentist/dental specialist has explained to me that a periodic evaluation is required in connection with the anesthesia permit issued to him/her by the Idaho State Board of Dentistry (“Board of Dentistry”). The Board of Dentistry is required to routinely conduct evaluations of all the anesthesia permit holders in Idaho. My dentist/dental specialist has further explained to me that it is necessary for one (1) or more Idaho State Board of Dentistry evaluators to personally observe the treatment provided to a patient. The evaluators are also dentists/dental specialists who are anesthesia permits holders in Idaho. My dentist/dental specialist has requested my consent to allow the Board of Dentistry’s evaluators to observe the treatment provided to me. Although my dentist/dental specialist may discuss my treatment with the evaluators and that the evaluators may discuss my treatment between themselves, I understand that the evaluators will treat any of the information they receive during their evaluation as confidential. Therefore, I hereby freely, knowingly and voluntarily consent to and authorize the Board of Dentistry’s evaluators to observe the treatment provided to me by my dentist/dental specialist. This consent shall be in full force and effect for a period of fourteen (14) days from the date of its execution, at which time it will expire.

Patient Signature

Date