



Georgia Society of Oral and Maxillofacial Surgeons

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Anesthesia On-site Inspection and Evaluation Form

Date Sent to Society _____

Name of Practitioner Evaluated General Anesthesia Permit Number (if applicable)

Location Inspected _____

Telephone Number _____

Date of Evaluation _____ Time of Evaluation _____

Names of Evaluators _____

A. PERSONNEL

1. ACLS Certificate (Please have doctor's ACLS Certification available)

2. PALS Certificate (if appropriate)

3. Evidence of: 1 year advanced training in anesthesiology, Fellow of the American Dental Society of Anesthesiology, Diplomate of the National Dental Board of Anesthesiology, Diplomate of the American Board of Oral and Maxillofacial Surgery, eligible for examination by American Board of Oral and Maxillofacial Surgery, or Fellow of the American Association of Oral and Maxillofacial Surgeons.

4. List of assisting staff's credentials/CV/training:

a. _____

b. _____

c. _____

B. RECORDS

Have available three charts of patients who have been treated in your office with intravenous sedation or general anesthesia.

1. An adequate medical history of the patient. Yes ___ No ___

2. An adequate physical evaluation of the patient. Yes ___ No ___

3. Anesthesia records showing: continuous monitoring of heart rate, blood pressure, and respiration using electrocardiographic monitoring and pulse oximetry. Yes ___ No ___

4. Recording of monitoring every 5 minutes. Yes ___ No ___

5. Evidence of continuous recovery monitoring, with notation of patient's condition upon discharge and person to whom the patient was discharged. Yes ___ No ___

6. Accurate recording of medications administered, including amounts and time administered. Yes ___ No ___

7. Records illustrating length of procedure. Yes ___ No ___
8. Records reflecting any complications of anesthesia. Yes ___ No ___

C. OFFICE FACILITY AND EQUIPMENT

1. Noninvasive Blood Pressure Monitor Yes ___ No ___
2. Electrocardiograph Yes ___ No ___
3. Defibrillator/Automated External Defibrillator Yes ___ No ___
4. Pulse Oximeter Yes ___ No ___
5. End-tidal Carbon Dioxide Monitor (required by January 2014) Yes ___ No ___
6. Operating Theater
- a. Is the operating theater large enough to adequately accommodate the patient on a table or in an operating chair? Yes ___ No ___
- b. Does the operating theater permit an operating team consisting of at least three individuals to move freely about the patient? Yes ___ No ___
7. Operating Chair or Table
- a. Does the operating chair or table permit the patient to be positioned so the operating team can 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 ___
8. 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 ___
9. 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 ___
10. Oxygen Delivery System
- a. Does the oxygen delivery system have adequate full-face masks and appropriate connectors, and is it capable of delivering oxygen to the patient under positive pressure? Yes ___ No ___
- b. Is there an adequate backup oxygen delivery system? Yes ___ No ___

11. Recovery Area (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 the recovery period? Yes ___ No ___

12. Ancillary 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 office outlets? Yes ___ No ___
- f. Are there endotracheal tube forceps? Yes ___ No ___
- g. Is there a sphygmomanometer and stethoscope? Yes ___ No ___
- h. Are there an electrocardioscope and defibrillator/automated external defibrillator? Yes ___ No ___
- i. Is there a pulse oximeter? Yes ___ No ___
- j. Is there adequate equipment for the establishment of an intravenous infusion? Yes ___ No ___

D. DRUGS

1. Vasopressor drug available? Yes ___ No ___
2. Corticosteroid drug available? Yes ___ No ___
3. Bronchodilator drug available? Yes ___ No ___
4. Muscle relaxant drug available? Yes ___ No ___
5. Intravenous medication for treatment of cardiopulmonary arrest available? Yes ___ No ___
6. Narcotic antagonist drug available? Yes ___ No ___
7. Benzodiazepine antagonist drug available? Yes ___ No ___
8. Antihistamine drug available? Yes ___ No ___
9. Antiarrhythmic drug available? Yes ___ No ___
10. Anticholinergic drug available? Yes ___ No ___
11. Coronary artery vasodilator drug available? Yes ___ No ___

12. Antihypertensive drug available? Yes ___ No ___

13. Mechanism of response for dantrolene (Dantrium®)? Yes ___ No ___

OVERALL EQUIPMENT — FACILITY _____ ADEQUATE _____ INADEQUATE

COMMENTS

RECOMMENDATIONS

Signature(s) of Evaluators _____

Printed Name(s) of Evaluators _____