STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

DENTAL SEDATION EVALUATION FORM

Permit: ☐ **General Anesthesia/deep Sedation** ☐ **Moderate Sedation Date of Evaluation:**_____

Name of Applicant: _____
Last *First* *Middle* *Maiden*

Primary professional address (site at which evaluation will be conducted)

_____
No. & Street *City* *State* *Zip Code*

Day time telephone number: _____ **Connecticut dental license number**: _____

Examiners (Please Print Name)

1 _____ Telephone _____

2 _____ Telephone _____

OFFICE EQUIPMENT

Except as specifically noted, all practitioners issued a permit shall demonstrate and maintain the following equipment. ***PLEASE CHECK IF EQUIPMENT PASSES INSPECTION AND LEAVE BLANK IF NOT.***

☐ Portable gas delivery system capable of positive pressure ventilation;

☐ Equipment capable of administering 100% oxygen in all rooms (operatory, recovery, examination, and reception);

☐ Portable bag-mask ventilator;
- ☐ adult; and
- ☐ pediatric;

☐ Full face mask;
- ☐ adult; and
- ☐ pediatric;

☐ Nasal hood or cannula;

☐ Oropharyngeal airways:
- ☐ adult; and
- ☐ pediatric;

☐ Nasopharyngeal airways:
- ☐ adult; and
- ☐ pediatric;

☐ Supraglottic airways
- ☐ adult; and
- ☐ pediatric;

☐ Endotracheal tubes with appropriate connectors and syringe for inflation, as follows:
- ☐ adult endotracheal tubes;
- ☐ Pediatric sized tubes;
- ☐ connectors;
- ☐ 10cc syringe for cuff inflation; and
- ☐ stylets to fit all tubes

☐ Laryngoscope, as follows:

- ☐ adult sized blade;
- ☐ pediatric sized blade;
- ☐ extra batteries;
- ☐ extra bulb (or extra blades if fiberoptic blades are used);

☐ Portable suctioning equipment capable of use during electrical power failure;
☐ Nasopharyngeal suction catheter
☐ Yankauer suction tip;
☐ Magill forceps;
☐ Tongue grasping forceps;
☐ Equipment to create an emergent surgical airway with connections;
☐ Defibrillator, AED or manual;
☐ Board or rigid surface for cardiopulmonary resuscitation (CPR);
☐ Emergency light source, for use during power failure;
☐ ECG;
☐ Capnography;
☐ Pulse oximetry;
☐ Stethoscope;

EQUIPMENT AND PERSONNEL FOR MONITORING PATIENTS:

☐ Blood Pressure monitor and cuffs:
- ☐ adult; and
- ☐ pediatric; and
- ☐ manual Sphygmomanometer
- ☐ ECG
- ☐ Capnography; or
- ☐ Pulse-oximetry
- ☐ Stethoscope;

☐ IV angio-catheters

☐ IV Tubing

☐ Operating chair or table located in operatory, which permits an operating team to have adequate space to perform two-person CPR.

EMERGENCY MEDICATION REQUIREMENTS FOR DENTAL ANESTHESIA/SEDATION PERMITTEES

- ☐ Anaphylaxis:
  - ☐ Epinephrine 1:1,000 for IM/SC injection, and
  - ☐ Epinephrine 1:10,000 for IV injection;

- ☐ Anticonvulsion Drug:
  - ☐ Midazolam; or
  - ☐ Diazepam

- ☐ Antiemetic Drug:
  - ☐ Ondansetron; or
  - ☐ Droperidol, or
  - ☐ Metoclopramide

- ☐ Antihistamine Drug:
  - ☐ Diphenhydramine

- ☐ Antihypertensive Drug:
  - ☐ Labetalol, and one (1) of the following Beta blockers:
    - ☐ Esmolol, or
    - ☐ Atenolol, or
    - ☐ Metoprolol

- ☐ Bronchodilator Drug
  - ☐ Albuterol inhaler

- ☐ Cardiovascular Agents:
  - ☐ Ephedrine, and
  - ☐ Adenosine, and
  - ☐ Diltiazem, and
  - ☐ Lidocaine, and
  - ☐ Amiodarone, and
  - ☐ Atropine, and

- ☐ Antiplatelet
  - ☐ Chewable acetylsalicylic acid (non-enteric coated aspirin)

- ☐ Corticosteroid Drug:
  - ☐ Dexamethasone, or
  - ☐ Methylprednisolone

- ☐ Hypoglycemic Drug
  - ☐ 50% dextrose solution

- ☐ Coronary Artery Vasodilator Drug
  - ☐ Nitroglycerin tablets; or
  - ☐ Nitroglycerin sublingual spray

☐ Intravenous Fluids for Resuscitation:

- ☐ Sterile water for injection for dilution of drugs, and
  - ☐ 0.9% sodium chloride for injection, or
  - ☐ D5/0.9% sodium chloride for injection, or
  - ☐ 0.45% sodium chloride for injection, or
  - ☐ D5/0.45% sodium chloride for injection, or
  - ☐ Lactated Ringer Solution for injection, or
  - ☐ D5 Lactated Ringer Solution for injection

☐ Malignant Hyperthermia Drug (only in facilities where volatile anesthetic inhalations are used)

- ☐ Dantrolene (sufficient quantity for initial treatment of a 75kg patient)

☐ Neuromuscular Blocking Drug

- ☐ Succinylcholine, or
- ☐ Rocuronium

☐ Reversal Agents

- ☐ Benzodiazepine Antagonist-Flumazenil, and
- ☐ Opiate/Opioid Antagonist-Naloxone

Personnel Requirements for Dental Anesthesia/Sedation Permittees

☐ Practitioner as defined in Section 20-123b-1, of the Regulations of Connecticut State Agencies, and is currently certified in BLS-HCP and ACLS, and

☐ Dentist licensed to practice dentistry pursuant to Chapter 379 of the Connecticut General Statutes, and is currently certified in BLS, or

☐ Assistant qualified through their professional scope, and licensed as required by Connecticut state law, to provide direct patient care to a patient under any level of sedation or general anesthesia, and is currently certified in BLS, or

☐ Dental Assistant as defined in Chapter 379 of the Connecticut General Statutes, and qualified to provide direct patient care to a patient under any level of sedation or general anesthesia and is currently certified in BLS.

NOTES: _____

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_____

RECORDS

All practitioners who are being evaluated shall maintain anesthesia or conscious sedation records which include the date of procedure, nothing by mouth (NPO) status, availability of responsible adult escort, allergies, vital signs, drugs, and doses administered.

☐ DATE ☐ NPO ☐ ESCORT ☐ V/S ☐ ALLERGIES ☐ DRUGS ☐ DOSES

CASE OBSERVATIONS

CASE #1

General Anesthesia/Deep Sedation ☐ **Moderate Sedation** ☐

Anesthetics: _____

Procedure: _____

Time: _____

Pass ☐ **Fail** ☐

Basis for failure, if applicable: _____

_____

Other remarks: _____

_____

CASE #2

General Anesthesia/Deep Sedation ☐ **Moderate Sedation** ☐

Anesthetics: _____

Procedure: _____

Time: _____

Pass ☐ **Fail** ☐

Basis for failure, if applicable: _____

_____

Other remarks: _____

_____

MEDICAL EMERGENCIES

	PASS	*FAIL*		*PASS*	*FAIL*
Laryngospasm	☐	☐	Acute M.I.	☐	☐
Broncospasm	☐	☐	Acute Hypotension	☐	☐
Emesis	☐	☐	Hypertensive Crisis	☐	☐
Aspiration	☐	☐	Convulsions	☐	☐
FB in Airway	☐	☐	CPR	☐	☐
Angina	☐	☐	Allergic	☐	☐
Syncope	☐	☐	Hyperventilation	☐	☐

EXIT INTERVIEW

Name of Applicant: _____Date of Site Evaluation: _____

_____

_____

_____

_____

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_____

_____

_____

_____

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_____

Practitioner: BCLS ☐ ACLS ☐

Staff: BCLS ☐ ACLS ☐

OUTCOME OF EVALUATION PASS ☐ FAIL ☐

EXAMINERS ***INITIALS***

1. _____License number _____ _____

2. _____License number_____ _____

PLEASE RETURN THIS EVALUATION FORM TO (Electronicaly or standard standard mail):

CT Society of Oral & Maxillofacial Surgeons
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Bloomfield, CT 06002
Email: clissitzyn@ssmgt.com
Tel: (860) 349-1471