STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.
DENTAL BOARD OF CALIFORNIA
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Courtesy Form for Reporting of Anesthesia Death or Hospitalization

Business and Professions Code, Section 1680(Z)(2)

PART 1 – REQUIREMENTS

Per Business & Professions Code § 1680 (z), the reporting of the death or hospitalization for cases in which patients received anesthesia are required to be submitted to the Board within seven (7) days and are required to include the following information on this form.

Are you reporting a: ☐ **Hospitalization** ☐ **Death**

PART 2 – NAME, CONTACT, AND LICENSEE INFORMATION

1. Dentist Name:_____
   First Middle Last
2. Address of Record:_____

   Incident Address (if different):_____
3. Telephone Numbers: Home:_____Office:_____Cell:_____
4. Email address:_____
5. CA License #(s):_____ Date Issued:_____
6. Sedation or General Anesthesia Permit #:_____Date Issued:_____
7. Other License # (if applicable):_____ Date Issued:_____

PART 3 – PATIENT INFORMATION

***For the purpose of #12-14 & #21, categories of providers are: General Dentist, Pediatric Dentist, Oral Surgeon, Dentist Anesthesiologist, Physician Anesthesiologist, Dental Assistant, Registered Dental Assistant, Dental Sedation Assistant, Registered Nurse, Certified Registered Nurse Anesthetist, or Other.**

1. Date of Procedure:_____
   And Date of Incident, if different:_____
2. Date Dentist Learned of Incident:_____
3. Patient Name:_____

4. Emergency Contact/Parent/Guardian:_____
   Address:_____
   Phone Number:_____

5. Patient's age (years and months):_____yrs_____mos.__

6. Patient's weight:_____BMI_____

7. Sex:_____

8. Patient's American Society of Anesthesiologists (ASA) physical status:
   _____

9. Patient's primary dental diagnosis:_____
   _____

10. Patient's coexisting diagnoses, diseases, or conditions:_____
    _____

11. Dental procedures performed:_____
    _____

12. Sedation/anesthesia setting:_____
    Location administered:_____

13. Medications administered and dosage:_____
    _____

14. Monitoring equipment utilized:_____
    _____

15. Permit category of the provider responsible for sedation/anesthesia oversight*****:_____

16. Permit category of the provider delivering sedation/anesthesia *****:_____
    _____

17. Permit category of the provider monitoring the patient during sedation/anesthesia *****:_____

18. Did the person supervising the sedation perform one or more of the procedures:_____

16. Planned airway management:_____
    _____

17. Planned depth of sedation/anesthesia:_____

18. Complications that occurred:_____

_____

19. Description of what was unexpected about the airway management:

_____

_____

20. Was there transportation of the patient during sedation/anesthesia:

_____

Time EMS called:_____ Time EMS arrived:_____

21. Location transported (Name of Hospital):_____

22. Permit category of the provider conducting resuscitation measures*****:

_____

23. Emergency resuscitation and Emergency medical equipment utilized:

_____

_____

PART 4 – Dentist Narrative of Event

*Please print or write legibly. Additional sheets may be attached as necessary.

_____

_____

_____

_____

_____

_____

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_____

This information is not an admission of guilt, but is for educational, data, or investigative purposes. Business & Professions Code §1680(z)(4)

_____ _____

Licensee's Signature Date