#### Record of Inhalation Sedation Patient Case

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|  **Case Number** |
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| **Dental Nurse Name:** | **Date:** |
| **Age of Patient & Relevant Medical History** |
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| **Pre Operative Checks Performed and Consent Details** |
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| **Treatment Required** |
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| **Inhalation Sedation Machine Set Up & Safety Checks Performed**(by dental nurse) |
| Breathing circuit replaced Correct size of nasal hood chosen Cylinders replaced if required Gas supplies checked   | **√** | N2O cut out checked Machine calibration checked Reservoir bag checked   | **√** |
| **Mechanical Monitoring During Treatment**  |
| **Flow Rate N2O** (litres/min): **Max Concentration of N2O** (%):**SpO2** (if recorded)**: Heart Rate** (if recorded)**:**  |
| **Clinical Monitoring Observations & Assessment of Operating Conditions** |
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| **Events/Complications During Recovery** |
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| **Supervising Dentist Name: Signature:** **Dental Nurse Signature: Date:** |
| **Assessor Signature: Date:** |