#### 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:** | | | | |