

Wisconsin Department of Safety and Professional Services

Office Location: 4822 Madison Yards Way
Madison, WI 53705
Phone Number: (608) 266-2112

LicensE Portal: <https://license.wi.gov/>
Email: dsps@wisconsin.gov
Website: <http://dsps.wi.gov>

DENTISTRY EXAMINING BOARD

PROCEDURE FOR REPORTING ADVERSE OCCURRENCES RELATED TO ANESTHESIA ADMINISTRATION

PER WISCONSIN ADMINISTRATIVE CODE:

Wis. Admin. Code § DE 11.10: Reporting of adverse occurrences related to anesthesia administration.

- A dentist shall report to the Dentistry Examining Board any anesthesia or sedation related mortality which occurs during or as a result of treatment provided by the dentist within two (2) business days of the dentist's notice of such mortality.
- A dentist shall report any morbidity which may result in permanent physical or mental injury as a result of the administration of anesthesia or sedation by the dentist to the Dentistry Examining Board within thirty (30) days of the notice of the occurrence of any such morbidity.
- The report shall include, at the minimum, responses to all of the following:
 1. A description of the dental procedures;
 2. The names of all participants in the dental procedure and any witnesses to the adverse occurrence;
 3. A description of the preoperative physical condition of the patient;
 4. A list of drugs and dosage administered before and during the dental procedures;
 5. A detailed description of the techniques utilized in the administration of all drugs used during the dental procedure;
 6. A description of the adverse occurrence, including the symptoms of any complications, any treatment given to the patient, and any patient response to the treatment; and
 7. A description of the patient's condition upon termination of any dental procedures undertaken.

Report the occurrence on the Report of Adverse Occurrences Related to Anesthesia Administration (**Form #2764**), obtainable from the Department of Safety and Professional Services at <http://dsps.wi.gov>. Select "*Professions*" from the main toolbar, then "*Dentist*."

Send (**Form #2764**) to the DSPPS office at Wisconsin Dentistry Examining Board, DSPPS, P.O. Box 8935, Madison, WI 53708-8935, A copy should be kept for your records. You may email to DSPPSCredDentistry@wisconsin.gov.

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DENTISTRY EXAMINING BOARD

REPORT OF ADVERSE OCCURRENCES RELATED TO ANESTHESIA ADMINISTRATION

PLEASE TYPE OR PRINT IN INK (Attach additional sheets if necessary.)

Name of Dentist: Last Name		First Name	MI	License Number
<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/>
Address (street, city, state, zip code)				Daytime Telephone Number
<input type="text"/>				<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Date of Occurrence:				
<input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>				
Patient's Reaction:				
<input type="text"/>				
Name(s)/Telephone Numbers of all participants in dental procedure and any witness to adverse occurrence:				
Name		Daytime Telephone Number		
<input type="text"/>		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
Name		Daytime Telephone Number		
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Type of Dental Procedures performed: (Provide a detailed description.):				
<input type="text"/>				
Description of the preoperative physical condition of the patient:				
<input type="text"/>				
Detailed description of techniques utilized in the administration of all drugs used during dental procedure:				
<input type="text"/>				
Description of the adverse occurrence, including symptoms of any complications, treatment given to patient, and patient response to the treatment:				
<input type="text"/>				
Description of patient's condition upon termination of any dental procedures undertaken:				
<input type="text"/>				

Please provide all dental charting relevant to this occurrence.

Wisconsin Department of Safety and Professional Services

LIST OF DRUGS AND DOSAGES ADMINISTERED BEFORE AND DURING THE DENTAL PROCEDURES

Drugs Administered Before Dental Procedure(s):

	Name of Drug	Dosage Strength and Form	Quantity
1.	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
2.	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
3.	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
4.	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
5.	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
6.	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
7.	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
8.	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
9.	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
10.	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

Drugs Administered During Procedure(s):

	Name of Drug	Dosage Strength and Form	Quantity
11.	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
12.	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
13.	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
14.	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
15.	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
16.	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
17.	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
18.	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
19.	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
20.	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

I certify that the foregoing information is correct to the best of my knowledge and belief.

Signature: Date: / /

(If unable to provide a digital signature print and sign form.)

Title: