## Questionnaire à retourner au conseil départemental

Conseil départemental de l'Ordre :

|  |
| --- |
| Nom et prénom du praticien : …………………………………………………………………………………… |
| Adresse du cabinet : ………………………………………………………………………………………………. |
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| **Hygiène et asepsie** |
|  | **OUI** | **NON** | **OBSERVATIONS** |
| **1/ “Hygiène des mains”** |  |  |  |
| * Solution hydroalcoolique
 |  |  | ………………………………………… |
| * Distribution eau :
 |  |  |  |
| * manuelle
 |  |  | ………………………………………… |
| * automatique
 |  |  | ………………………………………… |
| * Distributeur savon
 |  |  | ………………………………………… |
| * Essuie-mains :
 |  |  |  |
| * jetables
 |  |  | ………………………………………… |
| * non jetables
 |  |  | ………………………………………… |
| * Port de masque
 |  |  | ………………………………………… |
| * Port de gants
 |  |  | ………………………………………… |
| * Port de lunettes
 |  |  | ………………………………………… |
| **2/ Tenue professionnelle** |
| **Chirurgien(s)-dentiste(s)** |  |  |  |
| * Blouse à manches courtes
 |  |  | ………………………………………… |
| * Pantalon
 |  |  | ………………………………………… |
| * Gants
 |  |  | ………………………………………… |
| * Masque
 |  |  | ………………………………………… |
| * Lunettes de protection
 |  |  | ………………………………………… |
| * Chaussures dédiées
 |  |  | ………………………………………… |
| **Assistant(s) – Aide(s) dentaire(s)** : **à compléter uniquement si vous en employez un (ou plusieurs)** |  |  |  |
| * Blouse à manches courtes
 |  |  | ………………………………………… |
| * Pantalon
 |  |  | ………………………………………… |
| * Gants
 |  |  | ………………………………………… |
| * Masque
 |  |  | ………………………………………… |
| * Lunettes de protection
 |  |  | ………………………………………… |
| * Chaussures dédiées
 |  |  | ………………………………………… |
| **Autre** |  |  |  |
| * Préciser ………………………
 |  |  | ………………………………………… |
| * Tenue professionnelle spécifique
 |  |  | ………………………………………… |
| **3/ Protocole de stérilisation** |
| **Salle de soins** |  |  |  |
| * Prédésinfection surfaces travail entre chaque patient
 |  |  | ………………………………………… |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  | **OUI** | **NON** | **OBSERVATIONS** |
| **4/ Salle de stérilisation** |  |  |  |
| * Affichage du protocole de stérilisation
 |  |  | ………………………………………… |
| * Pré désinfection
 |  |  | ………………………………………… |
| * Bac(s) avec produits de désinfection
 |  |  | ………………………………………… |
| * Nettoyage
 |  |  |  |
| * Manuel
 |  |  | ………………………………………… |
| * Ultrasons
 |  |  | ………………………………………… |
| * Thermodésinfecteur
 |  |  | ………………………………………… |
| * Stérilisation :
 |  |  |  |
| * Autoclave vapeur d’eau
 |  |  | ………………………………………… |
| * Cycle prion
 |  |  | ………………………………………… |
| * Autoclave chimique
 |  |  | ………………………………………… |
| * Externalisation
 |  |  | ………………………………………… |
| * Autre…………….. préciser
 |  |  | ………………………………………… |
| * Traçabilité
 |  |  |  |
| * Test
 |  |  | ………………………………………… |
| * Conservation
 |  |  | ………………………………………… |
| * Matériel à usage unique
 |  |  | ………………………………………… |
| Instruments dynamiques |  |  |  |
| * Prédésinfection
 |  |  | ………………………………………… |
| * Nettoyage
 |  |  | ………………………………………… |
| * Stérilisation
 |  |  | ………………………………………… |
| * Matériel à usage unique
 |  |  | ………………………………………… |
| * Nettoyage des circuits d’eau entre chaque patient ou en début de journée
 |  |  | ………………………………………… |
| Externalisation entretien des locaux |  |  | ………………………………………… |
| **Radioprotection** |
| * Appareils de radiographie :
 |  |  |  |
| * Film argentique
 |  |  | ………………………………………… |
| * Numérique
 |  |  | ………………………………………… |
| * Panoramique
 |  |  | ………………………………………… |
| * Cone beam
 |  |  | ………………………………………… |
| * Téléradiographie
 |  |  | ………………………………………… |
| * Attestation de la formation radioprotection des patients
 |  |  | ………………………………………… |
| * PCR (personne compétente en radioprotection)
 |  |  | ………………………………………… |
| * Contrôle technique radioprotection
 |  |  | ………………………………………… |
| * Affichage zone radio (trèfle bleu)
 |  |  | ………………………………………… |
| **Contrats / Affichage / Relations avec les patients / Sécurité** |
| **Contrats** |
| * Elimination DASRI (Déchets d’activité de soins à risque infectieux)
 |  |  | ………………………………………… |
| * Assurance RCP (responsabilité civile professionnelle)
 |  |  | ………………………………………… |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  | **OUI** | **NON** | **OBSERVATIONS** |
|  |  |  |  |
| * Assurance locaux professionnels
 |  |  | ………………………………………… |
| * Contrats de maintenance :
 |  |  |  |
| * Autoclave
 |  |  | ………………………………………… |
| * Compresseur
 |  |  | ………………………………………… |
| * Radiologie
 |  |  | ………………………………………… |
| * Extincteur
 |  |  | ………………………………………… |
| * Autre……………. préciser
 |  |  | ………………………………………… |
| **Affichage salle d’attente et réception / Sécurité** |  |  |  |
| * Consignes incendie
 |  |  | ………………………………………… |
| * Extincteur(s) Préciser le nombre
 |  |  | ………………………………………… |
| * Numéros urgence
 |  |  | ………………………………………… |
| * Numéros permanence de soins et horaires
 |  |  | ………………………………………… |
| * Tarif des honoraires
 |  |  | ………………………………………… |
| * Affiche fichier informatique (RGPD)
 |  |  | ………………………………………… |
| * Interdiction de fumer
 |  |  | ………………………………………… |
| * Registre public d’accessibilité
 |  |  | ………………………………………… |
| **Relation avec les patients** |  |  |  |
| * Devis conventionnel
 |  |  | ………………………………………… |
| * Consentement éclairé du patient
 |  |  | ………………………………………… |
| * Passeport implantaire
 |  |  | ………………………………………… |
| * Déclaration conformité DMSM (Dispositif médical sur mesure)
 |  |  | ………………………………………… |
| * Protocoles avec mutuelle ou assurance(1)
 |  |  | ………………………………………… |
| * Attestation dédiée pour l’utilisation du MEOPA
 |  |  | ………………………………………… |
| **Sécurité** |  |  |  |
| * Urgences médicales :
 |  |  |  |
| * Trousse d’urgence « patients » - réanimation
 |  |  | ………………………………………… |
| * Trousse de secours « personnel » - Préciser le nombre
 |  |  | ………………………………………… |
| * Contrôle des installations électriques
 |  |  | ………………………………………… |
| **Equipe dentaire** |
| * Chirurgien(s)-dentiste(s)
 |  |  | ………………………………………… |
| * Assistante(s) dentaire(s) : enregistrement auprès de l’ARS **(à compléter uniquement si vous en employez un(e) ou plusieurs)**
 |  |  | ………………………………………… |
| * Aide(s) dentaire(s)
 |  |  | ………………………………………… |
| * Secrétaire
 |  |  | ………………………………………… |
| * Réceptionniste(s)
 |  |  | ………………………………………… |
| * Technicien(ne)(s) de surfaces
 |  |  | ………………………………………… |
| * Entreprise externalisation entretien locaux
 |  |  | ………………………………………… |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  | **OUI** | **NON** | **OBSERVATIONS** |
|  |  |  |  |
| * Prothésiste(s) dentaire(s)
 |  |  | ………………………………………… |
| **Affichage pour le personnel ou document mis à sa disposition** |  |  |  |
| * Convention
 |  |  | ………………………………………… |
| * Lutte contre le harcèlement
 |  |  | ………………………………………… |
| * Egalité professionnelle – Lutte contre les discriminations
 |  |  | ………………………………………… |
| * Coordonnées inspection du travail
 |  |  | ………………………………………… |
| * Coordonnées médecin du travail
 |  |  | ………………………………………… |
| * Règlement intérieur
 |  |  | ………………………………………… |
| * Procédure « conduite à tenir en cas d’AES »
 |  |  | ………………………………………… |
| * Affichage horaires
 |  |  | ………………………………………… |
| **Dispositions particulières au personnel** |  |  |  |
| * Visite médicale du personnel
 |  |  | ………………………………………… |
| * Document unique risques professionnels
 |  |  | ………………………………………… |
| **Les locaux / L’accessibilité** |
| **Aspect extérieur** |  |  |  |
| * Signalétique extérieure
 |  |  | ………………………………………… |
| **Accès handicapés** |  |  |  |
| * Locaux conformes
 |  |  | ………………………………………… |
| * Dérogation
 |  |  | ………………………………………… |
| **Accueil PMR** |  |  | ………………………………………… |
| **Locaux dispositifs médicaux** |  |  |  |
| * Unit(s) Préciser le nombre de cabinets
 |  |  | ………………………………………… |
| * Gestion des stocks produits :
 |  |  |  |
| * Inscription date d’ouverture
 |  |  | ………………………………………… |
| * Vérification des dates péremption
 |  |  | ………………………………………… |
| * La confidentialité est-elle assurée ?
 |  |  | ………………………………………… |
| **Sanitaires patients (WC)** |  |  |  |
| * Point d’eau « hygiène mains »
 |  |  | ………………………………………… |
| * Accessibilité aux personnes à mobilité réduite
 |  |  | ………………………………………… |
| **Vestiaires**  |  |  |  |
| * Individuel(s)
 |  |  | ………………………………………… |
| * Collectif
 |  |  | ………………………………………… |
| * Compartiment tenue professionnelle
 |  |  |  |
| **Local « stockage déchets »** |  |  |  |
| * Container DAOM (Déchets assimilés ordures ménagères)
 |  |  | ………………………………………… |
| * Container DASRI (Déchets activité de soins à risque infectieux)
 |  |  | ………………………………………… |
| **Local « entretien – ménage »** |  |  | ………………………………………… |
| **Salle de soins** |  |  | ………………………………………… |
| **Salle de stérilisation** |  |  | ………………………………………… |
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| **Informatisation du cabinet et dossiers médicaux** |
|  | **OUI** | **NON** | **OBSERVATIONS** |
|  |  |  |  |
| * Informatisation du cabinet
 |  |  | ………………………………………… |
| * Site internet Préciser URL
 |  |  | ………………………………………… |
| * Messagerie sécurisée entre professionnels de santé
 |  |  | ………………………………………… |
| **Dossiers médicaux** |  |  |  |
| * Dossiers :
 |  |  |  |
| * papier
 |  |  | ………………………………………… |
| * informatisés
 |  |  | ………………………………………… |
| * Registre des traitements (RGPD)
 |  |  | ………………………………………… |
| * Sécurité et confidentialité des données
 |  |  | ………………………………………… |
| * Sauvegarde :
 |  |  |  |
| * Interne au cabinet
 |  |  | ………………………………………… |
| * Externe au cabinet
 |  |  | ………………………………………… |
| * Archivage
 |  |  | ………………………………………… |

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Reproduire la phrase : "J’atteste sur l’honneur que les déclarations ci-dessus sont conformes à la vérité."

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Date : ……./ ……./ …….

Signature précédée de la mention manuscrite « Lu et approuvé » ……………………………………………………………….