## Questionnaire à retourner au conseil départemental

Conseil départemental de l'Ordre :

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| 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** |  |  | ………………………………………… | |  | | | | |  |  |  |  | |  |  |  |  | |  |  |  |  | | **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 |  |  | ………………………………………… | |

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 » ……………………………………………………………….