Your Hospital's Logo Here

DIAGNOSTIC SERVICES
Verification Checklist / Procedure Site

PATIENT IDENTIFICATION

PROCEDURE PERFORMED:	DATE:

INFORMED CONSENT:	☐ YES	☐ NO
INPATIENTS -and- OUTPATIENTS:		
PHYSICIAN PROGRESS NOTE -or- H & P (if applicable)	☐ YES	☐ NO
INITIAL ASSESSMENT SHEET	☐ YES	☐ NO
ANESTHESIA PRE-OP FORM	☐ YES	☐ NO
ORAL VERIFICATION OF PROCEDURE:		
PATIENT	☐ YES	☐ NO
ANESTHESIA (if applicable)	☐ YES	☐ NO
CARDIOLOGIST / RADIOLOGIST	☐ YES	☐ NO
RADIOLOGY TECHNOLOGIST	☐ YES	☐ NO
CARDIOVASCULAR TECHNOLOGIST	☐ YES	☐ NO
TO BE COMPLETED ON ALL PATIENTS:		
PRIMARY TECHNOLOGIST: Validate Presence of Permit	☐ YES	☐ NO
ANESTHESIA: Review Medical Record / Permit (if applicable)	☐ YES	☐ NO
DIRECT OBSERVATION OF INVASIVE SITE:		
CARDIOLOGIST / RADIOLOGIST	☐ YES	☐ NO
ANESTHESIA (if applicable)	☐ YES	☐ NO
RADIOLOGY TECHNOLOGIST	☐ YES	☐ NO
CARDIOVASCULAR TECHNOLOGIST	☐ YES	☐ NO
REVIEW OF PERTINENT X-RAYS & IMAGING BY CARDIOLOGIST / RADIOLOGIST:	☐ YES	☐ NO

RN's -or- Primary Technologist's SIGNATURE / TITLE:	DATE:

PART OF THE MEDICAL RECORD