HealthCare

DEPARTMENT OF NURSING
PRE - OPERATIVE CHECKLIST
DATE:_____

Complete checklist placing initials in "YES", "NO" columns

ITEM	YES	NO	COMMENTS: Record "N/A" if not ordered or not applicable. Disposition of items marked with "-" must be recorded.
I.D.Band On			
Surgical Consent Documented			
Anesthesia Consent Documented			
History & Physical Documented			
Allergies Noted			
NPO After ( )			
Blood Work Results on Chart			
Type & Hold Typenex Band On			
Consent for Blood Administration Documented			
Urinalysis Results on Chart			
EKG Interpretation on Chart			
Chest X-ray Results on Chart			
IV Access with #20 Gauge Needle or Larger			
BP Documented Within 2 Hours			
TPR documented Within 2 Hours			
Has Voided or Catheter Inserted			
Jewelry Removed and/or Rings Taped Includes all body piercings			
All Clothing Removed			
Hairpins/Makeup/Nail Polish Removed			
Contact Lens and/or Glasses Removed			
Dentures Removed			
Prosthesis Removed Record type of prosthetic device			
Side Rails Up			
Pre-Op Medication Administered as Ordered			
OR Notified if Patient in Isolation			
Other			

Unit Nurse: Signature/Title	Initials	Date	OR Nurse: Signature/Title	Initials