Addressograph

University of Medical Center

Surgical/Procedure Verification Protocol Checklist

PATIENT IDENTIFICATION

IDENTIFICATION

Section I. Complete in the Pre-op Areas unless the patient is admitted directly to the OR/Procedure Room.

Patient Identification:

- ☐ ID Band checked for Name and DOB, or Trauma Doe #.
- ☐ Patient Statement/Surrogate
- ☐ Patient Record Reviewed

Procedure: ______________________________

Procedure Confirmed By:

- ☐ Patient Statement/Surrogate
- ☐ Schedule
- ☐ Consent
- ☐ Patient Record Reviewed

Signature: ______________________________

Site Marking

Section II. to be completed by Practitioner performing the surgery or procedure (Check all applicable boxes)

☐ Left ☐ Right ☐ Bilateral ☐ Site Marking Not Applicable per policy

- ☐ Multiple sites simultaneously 1. ________ 2. ________ 3. ________ 4. ________ 5. ________
- ☐ Tooth/teeth removal marked on Dental Diagram (See Dental Diagram on page 2 of EP19)
- ☐ Site marked on radiologic image

Signature: ______________________________

FINAL VERIFICATION

Section III. Complete in OR Suite/Procedure Unit, or Patient Care Unit

Patient Identification:

- ☐ ID Band checked for name, or Trauma Doe # and DOB
- ☐ Patient Statement/Surrogate
- ☐ Patient Record Reviewed

Procedure: ______________________________

Procedure Confirmed By:

- ☐ Patient Statement
- ☐ Schedule ☐ Add-on schedule
- ☐ Consent ☐ MD Note
- ☐ Patient Record Reviewed
- ☐ X-ray film/imaging studies (if applicable) confirmed by Surgeon/Practitioner
- ☐ Dental Diagram/Site confirmed/verified by dentist/surgeon doing the procedure.
- ☐ Antibiotic given ☐ Yes ☐ No

AND TIME OUT

Section IV. Complete prior to incision or beginning of procedure

☐ **Time Out Completed** by surgical/procedure team by **verbally confirming:**

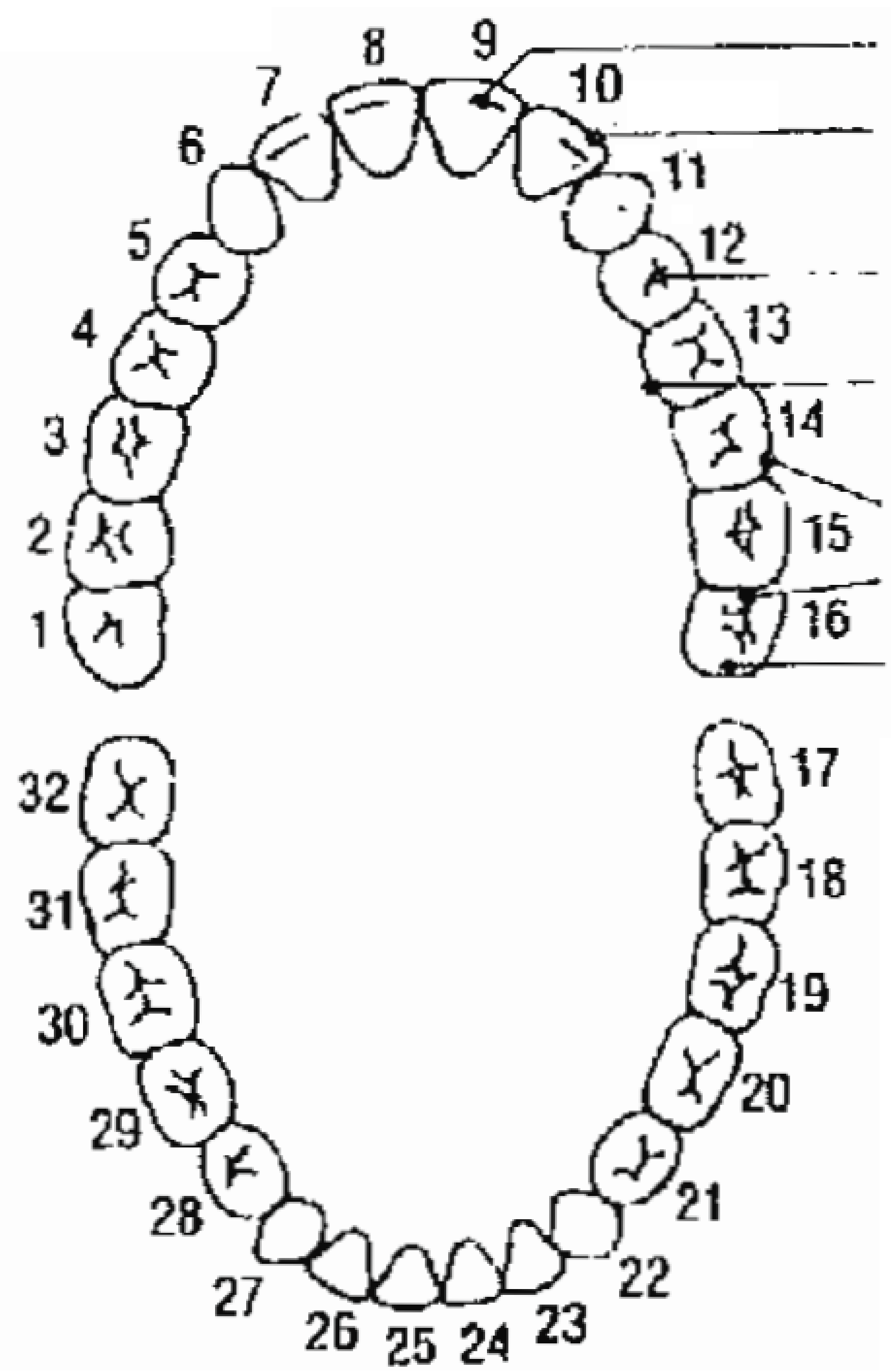
- patient identification
- surgery/procedure
- site/side if applicable
- patient position
- any special equipment
- required implants

MEMBERS PRESENT FOR TIME OUT

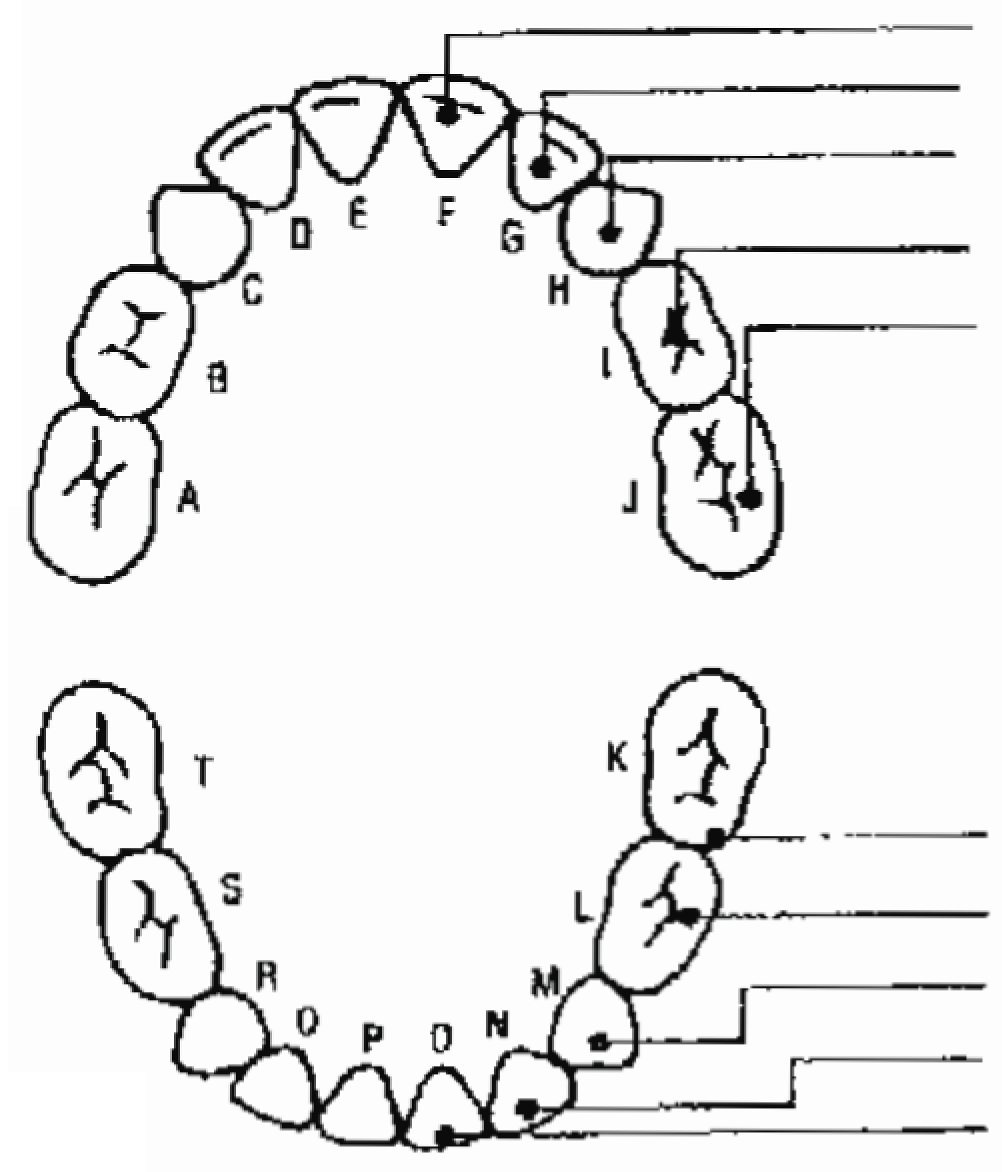
Print Name	Signature
______________	______________
______________	______________
______________	______________

Patient Name: ______________________ Medical Record No. ____________

ADULT



PEDIATRIC



(Rev. 11/04)