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**INVASIVE BEDSIDE PROCEDURE
VERIFICATION CHECKLIST
TO INCLUDE BONE MARROW Bx
& ASPIRATION, CHEST TUBE
PLACEMENT, LUMBAR
PUNCTURE, PARACENTESIS &
THORACENTESIS**

PATIENT IDENTIFICATION

DATE:	TIME:
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ITEMS TO BE CHECKED	YES	NO	N / A	EXPLAIN "NO" ANSWER	INITIALS
1. Procedure explained by the physician?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
2. Patient teaching completed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
3. ID Bands checked & verified using two (2) identifiers?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
4. Does patient have any known allergies? If "Yes", list 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	LIST KNOWN PATIENT ALLERGIES	
5. Procedure CONSENT FORM signed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
6. Specimen labels checked with patient's identification band?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
7. CBC, PT, PTT, etc. (if necessary) results reviewed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
8. All specimens labeled prior to leaving patient's room?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
9. VITAL SIGNS checked? PRE TIME: <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	T: <input type="text"/> BP: <input type="text"/>	P: <input type="text"/> R: <input type="text"/>
POST TIME: <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	T: <input type="text"/> BP: <input type="text"/>	P: <input type="text"/> R: <input type="text"/>

PHYSICIAN'S SIGNATURE: , MD	DATE:	NURSE'S SIGNATURE / TITLE:
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PART OF THE MEDICAL RECORD