COUNTY HOSPITAL
PREOPERATIVE CHECKLIST

Patient's Weight _____

Patient's Allergies _____

TPR _____

B/P _____

| | | FLOOR NURSE | SURGERY NURSE |
|---|---|---|---|
| 1. | I.D. BAND ON | _____ | _____ |
| 2. | SURGERY PERMIT SIGNED | _____ | _____ |
| 3. | H & P ON CHART | _____ | _____ |
| 4. | CONSULTATION ON CHART, if applicable | _____ | _____ |
| 5. | OPERATIVE AREA PREPPED IN SURGERY | _____ | _____ |
| 6. | BLOOD REPORTS ON CHART | _____ | _____ |
| 7. | URINALYSIS ON CHART | _____ | _____ |
| 8. | EKG REPORT ON CHART IF ORDERED | _____ | _____ |
| 9. | CHEST X-RAY REPORT ON CHART | _____ | _____ |
| 10. | NPO AFTER MIDNIGHT | _____ | _____ |
| 11. | DENTURES REMOVED | _____ | _____ |
| 12. | UNDERWEAR REMOVED | _____ | _____ |
| 13. | CONTACT LENS-GLASSES REMOVED | _____ | _____ |
| 14. | HEARING AID REMOVED | _____ | _____ |
| 15. | JEWELRY REMOVED OR TAPED | _____ | _____ |
| 16. | VOIDED OR CATHED | _____ | _____ |
| 17. | HAIRPINS, MAKEUP AND NAIL POLISH | _____ | _____ |
| 18. | CAP AND GOWN | _____ | _____ |
| 19. | NAME PLATE PRESENT | _____ | _____ |
| 20. | RECEIVED PRE-OP TEACHING | _____ | _____ |

PRE-OP MEDICATION, TIME AND NURSE _____

FLOOR NURSE: _____ OR NURSE _____

DATE: _____ DATE: _____