

HOSPITAL
TIME OUT
Verification Checklist

Addressograph

Date: _____

Procedure _____

Physician(s) / Practitioner(s): _____

Team members: _____

TIME OUT was initiated prior to procedure / incision (after prepping & draping) and verification of the following occurred:

Patient identification

Physician / Practitioner

Procedure

Site / side/ level / digit marked and visible to team Not applicable

(Operating Room only) Required implants available Not applicable

All team members are in agreement

TIME OUT was called at _____ Signature: _____

When applicable:

Verification TIME OUT as above initiated on arrival of the second physician/practitioner.

Signature: _____ Time: _____