MEDICAL RECORD – UNIVERSAL PROTOCOL: PROCEDURE VERIFICATION CHECKLIST

For use of this form see MEDCOM Reg 40-54: the proponent agency is MCHO-CL-Q

List of Procedures:

PRE-PROCEDURAL CONFIRMATION

With patient involvement (when possible) prior to pre-op medication Administration. All signatures must be signed in sequence.

Operating Provider List Procedure(s):

I have verified ALL of the following:

a) Patient identification, consent, H&P/progress note, relevant diagnostic and radiologic tests are accurate, readily available and properly labeled.
b) I have marked at or near the procedural site with my initials ((or used Alternative Marking Method).
c) Required blood products, implants, devices and/or special equipment are available.

Provider Signature:

Pre-Procedural Area Provider Signature

_____
____ Date/Time: _____

Procedural Assistant (RN, Radiology Tech, Medic, etc.) ***Use not Applicable if not part of the procedural Team***

I have verified all of the following:

a) Patient identification confirmed, consent(s), and H&P/progress note are consistent with plan of care.
b) The provider's initials are visible at or near the procedural site(s) (or Alternate Marking Method is used) and consistent with the operative plan.
c) Required implants, devices and/or special equipment are available.

☐ Not Applicable

Nurse/Assistant Signature:

Pre-Procedural Area: Procedural Assistant (RN, Rad Tech, Medic, etc.)

_____
____ Date/Time: _____

Anesthesia Provider ***Use not Applicable if not part of the procedural Team***

I have verified all of the following:

a) Patient identification confirmed with ID band; consent(s) and H&P/progress note are consistent with plan of care.
b) The operating provider's initials are visible at or near the procedural site(s) (or Alternate Marking Method is used) and consistent with the operative plan.
c) Required blood products and special equipment are available.

☐ Not Applicable

Anesthesia Provider Signature:

Pre-Procedural Area Anesthesia Provider Signature

_____
____ Date/Time: _____

Patient (If alert and prior to preprocedure medication.)

a) Patient confirms name and DOB
b) Patient confirms procedure
c) Patient confirms laterality

☐ Not Applicable

Patient Signature:

Pre-Procedural Area: Patient Signature

_____
_____ Date/Time:
_____

PROCEDURAL AREA TIME-OUT

The operating provider led the operating team using interactive verbal communication and confirmed the following:

a) Patient identification confirmed with the ID band; consent is consistent with planned procedure and completed.
b) Provider's initials are visible and the correct side/site is marked (or Alternate Marking Method is used).
c) Patient's position is appropriate for the planned procedure.
d) Required items are available (images, equipment, implants, blood products, etc.).
e) The need to administer antibiotics or fluids for irrigation purposes has been addressed.
f) Safety precautions based on patient history or medication use have been identified.
g) Team agrees on procedure to be done.
h) Fire Risk Assessment complete. or

☐

Discrepancy noted and procedure(s) aborted. Signature:

Licensed Staff Signature:

Procedural Area Time-Out: Licensed Staff Signature

_____
_____ Date/Time:
_____

PATIENT'S IDENTIFICATION (For typed or written entries give: Name – last, first, middle; grade; date; hospital or medical facility)	**Notes:**
Name: PatientName Patient Category: Patient Category: Gender: DoD ID: DOB: PatientDOB	Procedure site or incision above xiphoid? ☐ ☐ Open Oxygen source (face mask/nasal cannula)? ☐ ☐ Ignition source (cautery, laser, fiberoptic light)? ☐ ☐ ☐ **Score of 1 or 2: Routine Protocol** **Score of 3: High Risk protocol** Yes = 1 (1st column) No = 0 (2nd column)