**PREOPERATIVE CHECKLIST**

**Proposed Operation**

<table>
<thead>
<tr>
<th>I. PSYCHOLOGICAL PREPARATION</th>
<th>INITIALS</th>
<th>II. PATIENT'S CHART</th>
<th>INITIALS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Preoperative Teaching</strong></td>
<td></td>
<td><strong>A. Consents</strong></td>
<td></td>
</tr>
<tr>
<td>1. Visiting Regulations</td>
<td></td>
<td>1. Operative</td>
<td></td>
</tr>
<tr>
<td>2. Turn, Cough, Deep Breath</td>
<td></td>
<td>signed and witnessed</td>
<td></td>
</tr>
<tr>
<td>3. Inspiratory Spirometry</td>
<td></td>
<td>2. Blood Transfusion Consent</td>
<td>signed and witnessed</td>
</tr>
<tr>
<td>4. Ambulation/Exercise</td>
<td></td>
<td>3. 30 Day Sterilization Consent</td>
<td>signed and witnessed</td>
</tr>
<tr>
<td>5. O2 treatments/Tubes/Drains</td>
<td></td>
<td>4. Limb Disposal Consent</td>
<td>signed and witnessed</td>
</tr>
<tr>
<td>6. Presurgical Unit/Recovery Room</td>
<td></td>
<td>5. Other</td>
<td></td>
</tr>
<tr>
<td>7. Pre-and-Post Operative Procedures</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. NPO / Diet Restrictions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Audiovisual Aid, shown (if available)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>B. Emotional Assessment</strong></th>
<th></th>
<th><strong>B. Preoperative Tests</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Assess understanding of proposed surgery and answer questions as necessary</td>
<td></td>
<td>1. Chest X-Ray</td>
<td></td>
</tr>
<tr>
<td>2. Handicaps or special precautions (check what is applicable)</td>
<td></td>
<td>2. Blood Type &amp; Crossmatch: number of units component</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. EKG</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Consults</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>5. Laboratory Tests</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>e. Clin-Chem</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>f. Sickle Cell Prep/Electrophoresis</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>g. RPR</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>h. Other</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>i. Post-Partum Hematocrit</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>j. Other</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>k. Other</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>l. Other</td>
<td></td>
</tr>
</tbody>
</table>

[3479]
### III. PHYSICAL PREPARATION

<table>
<thead>
<tr>
<th>B. Hygiene</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Shave Prep</td>
</tr>
<tr>
<td>2. Shower/Bath</td>
</tr>
<tr>
<td>3. Oral Hygiene</td>
</tr>
<tr>
<td>4. Bowel Prep</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C. Personal Effects</th>
<th>Removed</th>
<th>Not Rem'd</th>
<th>Disposition/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Dentures</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Jewelry</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Wigs/Hair Accessories/Cosmetics/Nail Polish</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Eye Glasses/Contacts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Hearing Aids</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Prostheses: Limb</td>
<td>Eye</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D. Valuables and personal belongings secured:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E. I.D. Bands (2)</th>
<th>Allergy</th>
<th>Other</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>F. Wearing Hospital gown only</th>
<th>Exceptions</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>G. NPO since:</th>
<th>Void, time:</th>
<th>am pm</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>H. Tubes/Drains/Foley present (type)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>I. Neonatal Patients:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transport bed temperature</td>
</tr>
<tr>
<td>O₂ PSI in cylinder</td>
</tr>
</tbody>
</table>

### J. PREPARATIONS / PREOPERATIVE MEDS

<table>
<thead>
<tr>
<th>IV SOLUTION / AMOUNT:</th>
<th>IV STARTED BY:</th>
<th>TIME</th>
<th>TAKEN TO:</th>
</tr>
</thead>
<tbody>
<tr>
<td>SITE</td>
<td>CATH SIZE</td>
<td>TIME</td>
<td>VIA</td>
</tr>
<tr>
<td>PRIF-OP ANCHOR CHECK</td>
<td>TIME</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TIME</td>
<td>MEDICATION</td>
<td>DOSE</td>
<td>ROUTE</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NURSES’ NOTES</th>
</tr>
</thead>
</table>

### IV. TRANSFER TO OR (Please Check)

- Current chart
- Clinic chart
- Addressograph plate
- Interim summary
- Bedside records
- X-Rays

<table>
<thead>
<tr>
<th>I. NURSES’ INITIALS &amp; SIGNATURE</th>
</tr>
</thead>
</table>