HOSPITAL

PREOPERATIVE CHECK LIST

☐ YES O.R. PERMIT SIGNED BY PATIENT/ON CHART
☐ YES O.R. PERMIT SIGNED BY SURGEON
☐ YES O.R. PERMIT SIGNED BY ANESTHESIOLOGIST
☐ YES H/P ON CHART
☐ YES O NA, CBC, BMP, BETA DTA & LABS ON CHART
☐ YES D NA EKG DONE REPORT ON CHART
☐ YES D NA CHEST X-RAY DONE REPORT ON CHART

PREOPERATIVE VITAL SIGNS (WITHIN 1-HOUR PRIOR TO OR)

TIME:

TEMP: ________ HR: ________ BP: ________ RR: ________ O2 ______

Operative Side/Site Verification - Inpatient Unit D N/A

Operative Side Verified as __________________________ by ____________ RN

Operative Side/Site Verification - Ambulatory Surgery Unit D N/A

Operative Side Verified as __________________________ by ____________ RN

Operative Side / Site Verification & Site Signature Verification: OR Nurse Preoperative: D N/A

Operative Side Verified as __________________________ by ____________ RN

Operative Side Signed by Surgeon Verified by ____________ RN

☐ YES IDENTIFICATION BAND ON PATIENT
☐ YES PATIENT NPO AS ORDERED
☐ YES PRE-OP ANESTHESIA QUESTIONNAIRE COMPLETED ON CHART
☐ YES ALLERGIES NOTED ON CHART:

☐ YES NURSING DATA BASE COMPLETED ON CHART
☐ YES ADVANCE DIRECTIVES NOTED ON DATA BASE/CHART D NO INFORMATION PROVIDED

☐ YES PATIENT VOIDED DYES D NO URINARY CATHETER
☐ YES D PACEMAKER D NO IMPLANTED PACEMAKER
☐ YES D NA HAIRPIECES/PINS REMOVED
☐ YES D NA JEWELRY REMOVED
☐ YES D NA DENTURES REMOVED
☐ YES D NA EYEGGLASSES/CONTACTS REMOVED
☐ YES D NA HEARING AID(S)/PROSTHESIS REMOVED

ASSESSMENT OF PATIENT STATUS UPON TRANSFER TO THE OR:

ADDITIONAL COMMENTS:


PATIENT CHART REVIEW/ALL COMPONENTS VERIFIED AS COMPLETE AND THE PATIENT IDENTIFIED BY:

OR NURSE SIGNATURE: ____________ OR NURSE (PRINT): ____________ TIME: ____________ DATE: ____________

ACC USE ONLY

ITEM

REQUIRED

ACC RN SIGNATURE: ____________ DATE: ____________ TIME: ____________

X-ray
CXR

ACC COMMENTS:

Cardiology
EKG

LAB
Urinalysis
CBC
BMP
CMP

DATA HCG
PT/PTT

Meds
Pre-Op