

		PRE-PROCEDURE CHECKLIST (check (✓) all that apply)	COMPLETED (✓)	INITIALS
NEEDS ASSESSMENT FOR ADDITIONAL DIAGNOSTICS STUDIES	1.	History and physical completed: Valid date (30 days/heart & lung within 7 days) Performed by Physician Assistant/Nurse Practitioner	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> N/A	
	2.	<input type="checkbox"/> CBC <input type="checkbox"/> BMP <input type="checkbox"/> CMP <input type="checkbox"/> PT <input type="checkbox"/> PTT <input type="checkbox"/> ESR	<input type="checkbox"/> Yes <input type="checkbox"/> N/A	
	3.	<input type="checkbox"/> Type and Screen <input type="checkbox"/> Autologous <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> N/A	
	4.	CXR-per anesthesia requirements, or as ordered by physician.	<input type="checkbox"/> Yes <input type="checkbox"/> N/A	
	5.	EKG-per anesthesia requirements, or as ordered by physician.	<input type="checkbox"/> Yes <input type="checkbox"/> N/A	
	6.	U/A (only if ordered by physician)	<input type="checkbox"/> Yes <input type="checkbox"/> N/A	
	7.	Pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A	
	8.	Pregnancy Test result on chart: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A	
	9.	Call Surgeon, Anesthesiologist, or Radiologist with abnormal reports.	<input type="checkbox"/> Yes <input type="checkbox"/> N/A	
	10.	Diabetic patients: Accucheck, blood sugar level / charted (if less than 90 or greater than 200 report to anesthesiologist).	<input type="checkbox"/> Yes <input type="checkbox"/> N/A	
	11.	Additional tests required: <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> N/A	
CHART PREPARATION	12.	Written procedure on Consent exactly matches the: <input type="checkbox"/> H & P <input type="checkbox"/> Physician's Order <input type="checkbox"/> Surgical/Procedure Schedule <input type="checkbox"/> Diagnostic studies (including Radiology) <input type="checkbox"/> Patient confirmation	<input type="checkbox"/> Yes	
	13.	Procedure/Operative Consent signed by patient/legal other: <input type="checkbox"/> Witnessed <input type="checkbox"/> Sterilization <input type="checkbox"/> Refusal of blood products	<input type="checkbox"/> Yes	
	14.	Nursing history and assessment on chart and Nursing Plan of Care reviewed.	<input type="checkbox"/> Yes	
	15.	Advance Directives (patient 18 years and older) on chart/information given/charted.	<input type="checkbox"/> Yes <input type="checkbox"/> N/A	
	16.	<input type="checkbox"/> Reversal of DNR Form on chart <input type="checkbox"/> DNR Form on chart	<input type="checkbox"/> Yes <input type="checkbox"/> N/A	
	17.	50 Labels placed in chart pocket.	<input type="checkbox"/> Yes	
	18.	In-house patients: MAR, Kardex, Flow charts placed on chart.	<input type="checkbox"/> Yes <input type="checkbox"/> N/A	
	19.	<input type="checkbox"/> Vital signs charted: <input type="checkbox"/> Arterial Line <input type="checkbox"/> CVP <input type="checkbox"/> Weight <input type="checkbox"/> SaO2	<input type="checkbox"/> Yes	
	20.	<input type="checkbox"/> ID bracelet on and verified. <input type="checkbox"/> If Allergic, Allergy Band on with allergies noted.	<input type="checkbox"/> Yes	
PATIENT PREPARATION	21.	Determination of last oral intake: <input type="checkbox"/> NG tube <input type="checkbox"/> NPO from solids (Date/Time _____) <input type="checkbox"/> NPO from liquids (Date/Time _____)	<input type="checkbox"/> Yes	
	22.	Skin condition assessed	<input type="checkbox"/> Yes <input type="checkbox"/> N/A	
	23.	<input type="checkbox"/> Emotional status assessed. <input type="checkbox"/> Level of consciousness assessed. <input type="checkbox"/> Restraints.	<input type="checkbox"/> Yes <input type="checkbox"/> N/A	
	24.	IV infusing as ordered by Physician.	<input type="checkbox"/> Yes <input type="checkbox"/> N/A	
	25.	<input type="checkbox"/> Voided. <input type="checkbox"/> Foley Emptied.	<input type="checkbox"/> Yes <input type="checkbox"/> N/A	
	26.	Jewelry (secured), piercings, clothing, hairpins removed & location documented.	<input type="checkbox"/> Yes <input type="checkbox"/> N/A	
	27.	Glasses / Contact Lenses / Hearing Aid removed & location charted.	<input type="checkbox"/> Yes <input type="checkbox"/> N/A	
	28.	<input type="checkbox"/> Dentures / partials in mouth / charted. <input type="checkbox"/> Dentures / partials removed / location charted	<input type="checkbox"/> Yes <input type="checkbox"/> N/A	
	29.	<input type="checkbox"/> Routine Medication given (See MAR). <input type="checkbox"/> PRN Meds given (See MAR). <input type="checkbox"/> Pre-Op medication given (See MAR). <input type="checkbox"/> Pre-Op Med sent with patient.	<input type="checkbox"/> Yes <input type="checkbox"/> N/A	
	30.	Special order (specify): <input type="checkbox"/> Shave or prep as ordered.	<input type="checkbox"/> Yes <input type="checkbox"/> N/A	
VERIFICATION	31.	Written procedure on Consent exactly matches the: <input type="checkbox"/> H & P <input type="checkbox"/> Physician's Order <input type="checkbox"/> Surgical/Procedure Schedule <input type="checkbox"/> Diagnostic studies (including Radiology) <input type="checkbox"/> Patient confirmation	<input type="checkbox"/> Yes	
	32.	History and physical signed / initialed by SGAH Physician.	<input type="checkbox"/> Yes	
	33.	Anatomical site marked by patient, physician or orange armband on.	<input type="checkbox"/> Yes <input type="checkbox"/> N/A	
	34.	Procedure / Operative Consent Signed by Physician and Dated:	<input type="checkbox"/> Yes	
	35.	Anesthesia Evaluation / Consent Signed by Anesthesiologist and Dated:	<input type="checkbox"/> Yes <input type="checkbox"/> N/A	
DATE: _____ INTL: _____ SIGNATURE _____		DATE: _____ INTL: _____ SIGNATURE _____		
DATE: _____ INTL: _____ SIGNATURE _____		DATE: _____ INTL: _____ SIGNATURE _____		

Patient

Hospital  
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