

MEDICAL RECORD - UNIVERSAL PROTOCOL: PROCEDURE VERIFICATION CHECKLIST <small>For use of this form, see MEDCOM Reg 40-54; the proponent agency is MCHO-CL-Q</small>	
List of Procedure(s):	# of Consents:
PRE-PROCEDURAL AREA <small>With patient involvement (when possible) prior to pre-op medication administration</small>	
Clinical Staff I have verified ALL of the following: a) Patient's full name and birth date are consistent with consent(s). b) Consent is complete (including side/level/site), accurate and is signed and dated by provider, patient and witness. Additional procedure consents for this operative event are acknowledged.	Clinical Staff Signature: Date: Time:
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 Alternate Marking Method). c) Required blood products, implants, devices and/or special equipment are available.	Provider Signature: Date: Time:
Verifications Immediately Prior to Patient Transfers to Procedure Area (After above verifications have been completed)	
Circulating Nurse / Holding Area Nurse / Procedural Assistant 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.	Nurse/Assistant Signature: Date: Time:
Anesthesia Provider <input type="checkbox"/> <i>Not Applicable</i> 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.	Anesthesia Provider 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. 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. or <input type="checkbox"/> <i>Discrepancy noted and procedures aborted. Signature:</i>	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:

