



**NON-SEDATION PRE-PROCEDURE CHECKLIST  
UNIVERSAL PROTOCOL**

Inconsistencies in the operative/procedural process  
must be resolved before proceeding.

2-Hole 1/4 2 3/4 - 3-Hole 1/4 4 1/4

PHYSICIAN'S PRE-PROCEDURE ASSESSMENT

Indications \_\_\_\_\_

Patient has indicated no Allergies relevant to the procedure (including contrast):  
List if "No" \_\_\_\_\_

Yes No

Patient has been asked regarding potential pregnancy  
(Female patients age 12-60)

I have reviewed the patient's medications and any laboratory values relevant to this procedure.

Patient condition:

Alert and oriented X 3

Stable and adequate to tolerate the procedure

List any other information pertinent to the procedure:

\_\_\_\_\_  
\_\_\_\_\_

UNIVERSAL PROTOCOL

TIMEOUT: Verifying the Correct Patient - Correct Procedure - Correct Procedure Site Checklist

1. Pre-procedure the nurse/designated caregiver has verified the correct procedure and location of  
the procedural site with the patient and with a minimum of two of the following relevant records:

- Procedure consent
- History and physical
- Progress Note
- Procedural schedule of day of procedures
- Physician order for procedure

2. Images, equipment and special requirements are available as needed

"TIME OUT" CONDUCTED AUDIBLY:

3. Correct patient identified using two patient identifiers

4. Agreement of correct procedure

5. Correct site of procedure

6. Correct side  Left  Right  Bilateral

7. Procedure/Operative site marked and visible

8. Correct patient position

(PRINT legibly name and credentials) \_\_\_\_\_

Date \_\_\_\_\_ Time \_\_\_\_\_ Signature \_\_\_\_\_

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### PATIENT CONSENT TO PROCEDURE

With form for provider to verify: correct patient, procedure and site

PATIENT:

UNIT NO:

PROCEDURE:

- Right
- Left
- Both Sides
- Not applicable

I understand my illness/medical condition and the procedure/surgery I will be having. I understand the risks and benefits I can reasonably expect from this procedure/surgery, compared to those I could expect from other approaches.

I understand the risks and the possibility of major complications of this procedure/surgery. I understand that among the risks of this procedure are: drug reactions, bleeding, infection, and complications from receiving blood or blood components. I also understand that, as with every procedure/surgery, there is the possibility of unexpected complications.

The following additional specific risks or issues were discussed with me: **[Physician/Licensed Practitioner, please list]**

- I received teaching materials to help me understand the information explained to me.
- Procedural sedation will be used during this procedure/surgery to control my pain. I understand that this method of pain control has risks, including the possibility of suppressed breathing, low blood pressure and, sometimes, incomplete pain relief.

Doctor \_\_\_\_\_ will perform my procedure/surgery.

I understand that Massachusetts General Hospital (MGH) is a teaching hospital. This means that resident doctors, doctors in medical fellowships (fellows) and students in medical, nursing, and related health care professions receive training here. These doctors and students may take part in my procedure/surgery. My doctor will determine when it is necessary or appropriate for others to participate in my procedure/surgery and care.

I understand that this procedure/surgery may have significant educational or scientific value. The hospital may photograph, videotape, or record my procedure/surgery for teaching purposes. Any information used for these purposes will not identify me.

I understand that blood or other samples removed to treat or diagnose my condition may later be thrown away by MGH. These materials also may be used by MGH, by medical organizations connected to MGH, or by educational or business organizations approved by MGH, for research, education and other activities that support MGH's mission.

I have had an opportunity to ask about the risks and benefits of this procedure/surgery and of the alternatives. All my questions have been answered to my satisfaction, and I consent to this procedure/surgery:

Date \_\_\_\_\_ Time \_\_\_\_\_ AM/PM \_\_\_\_\_

Signature (patient/health care agent/guardian/family member) (If patient's consent cannot be obtained, indicate reason above.)

I attest that I discussed all relevant aspects of this procedure/surgery, including the indications, risks, and benefits, as compared with alternative approaches, with the patient, and answered his/her questions.

Date \_\_\_\_\_ Time \_\_\_\_\_ AM/PM \_\_\_\_\_

Signature (Physician/Licensed Practitioner)

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