



MR# _____
 LW Acct# _____
 Name _____

Procedure Date
 / /

Complete or Imprint with Address-O-Plate

**Procedure, Site Verification,
 & Patient Identification
 Universal Protocol Checklist**

VERIFICATION #1 Date _____

Location SDA/SPU Inpatient Room Other: _____

Operative/Invasive Procedure Stated By Patient
 N/A _____ Other _____ Relationship to Patient _____

Procedure on Left Side of Body
 (complete form on Left Side)

Consent Completed and In Chart Yes No
 Comments: _____

Correct Patient Verification Name DOB
 Staff Signature/Title _____

All Other Procedures (complete form in center)
 (including non-lateral and bilateral)

Consent Completed and In Chart Yes No
 Comments: _____

Correct Patient Verification Name DOB
 Staff Signature/Title _____

Procedure on Right Side of Body
 (complete form on Right Side)

Consent Completed and In Chart Yes No
 Comments: _____

Correct Patient Verification Name DOB
 Staff Signature/Title _____

VERIFICATION #2 (Day of Procedure) Date _____

Operative/Invasive Procedure (as stated by patient)
 N/A _____

Location Holding ED Radiology Critical Care Bedside CVIR Procedure Room Endoscopy
 Invasive Cardiology Labor/ Delivery Bronchoscopy Other _____

Procedure on Left Side of Body
 (complete form on Left Side)

Consent Completed and In Chart Yes No
 Comments: _____

Correct Patient Verification Name DOB
 Physician Marking Site _____

Site Marked Yes No N/A
 Site Verified By Patient Yes No N/A
 Staff Signature/Title _____

All Other Procedures (complete form in center)
 (including non-lateral and bilateral)

Consent Completed and In Chart Yes No
 Comments: _____

Correct Patient Verification Name DOB
 Physician Marking Site _____

Site Marked Yes No N/A
 Site Verified By Patient Yes No N/A
 Staff Signature/Title _____

Procedure on Right Side of Body
 (complete form on Right Side)

Consent Completed and In Chart Yes No
 Comments: _____

Correct Patient Verification Name DOB
 Physician Marking Site _____

Site Marked Yes No N/A
 Site Verified By Patient Yes No N/A
 Staff Signature/Title _____

Correct Patient Identification Verified

Primary Operating Team Surgeon/Bedside Invasive Team Practitioner Signature _____ Date _____ Time _____

VERIFICATION #3 (Immediately Prior to Procedure) Date _____ Time _____

Operative/Invasive Procedure (as stated by patient)
 N/A _____

Procedure on Left Side of Body
 (complete form on Left Side)

Verification Correct Patient/Procedure/Site Yes No
 Comments: _____

Site Mark Visible: Yes No

Consent read aloud (immediately before incision: Time Out) Yes No
 Comments: _____

Patient Position _____

X-Ray labeled/displayed correctly in room Y N N/A

Available in room:
 Special Equipment: Yes No N/A
 Implants: Yes No N/A
 Comments: _____

All Other Procedures (complete form in center)
 (including non-lateral and bilateral)

Verification Correct Patient/Procedure/Site Yes No
 Comments: _____

Site Mark Visible: Yes No

Consent read aloud (immediately before incision: Time Out) Yes No
 Comments: _____

Patient Position _____

X-Ray labeled/displayed correctly in room Y N N/A

Available in room:
 Special Equipment: Yes No N/A
 Implants: Yes No N/A
 Comments: _____

Procedure on Right Side of Body
 (complete form on Right Side)

Verification Correct Patient/Procedure/Site Yes No
 Comments: _____

Site Mark Visible: Yes No

Consent read aloud (immediately before incision: Time Out) Yes No
 Comments: _____

Patient Position _____

X-Ray labeled/displayed correctly in room Y N N/A

Available in room:
 Special Equipment: Yes No N/A
 Implants: Yes No N/A
 Comments: _____

Team Members Participating

Physician Name _____ Anesthesia Name _____

Staff Signature & Title (Signature of Operating Room Circulating Nurse or Bedside Procedure Team Member is Required) _____ Date _____ Time _____

IMPORTANT: DO NOT WRITE IN MARGINS