PRE-PROCEDURE CHECKLIST

Date ________ **Patient's Name** ____________________

MRN __________ DOB/Age ___________ Wt _________

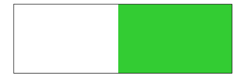
PROCEDURE ______________________________

Staff Participants __________________________

ALL ITEMS MUST BE CONFIRMED BY **2** TEAM MEMBERS

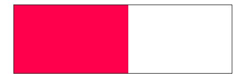
Red Not Confirmed | Green Confirmed

1. Patient Identification
   TWO Identifiers



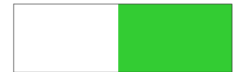
LABS

2. Allergies



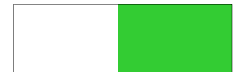
PLT ____

3. Consent Signed?



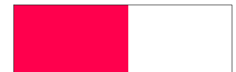
PTT ____

4. History & Physical



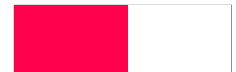
INR ____

5. Site Verification R/L



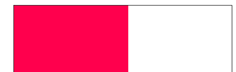
Hgb ____

6. Implants/Special Equipment*



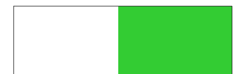
Hct ____

7. Radiological Exams



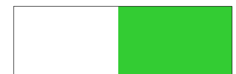
WBC ____

8. Antibiotics
   ____



Cr ____

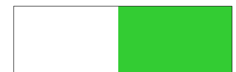
9. ABO Compatibility



BUN ____

10. Surgical Pause

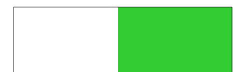
11. ____________________



12. ____________________

*If Applicable

13. ____________________



Indelta Learning Systems
866-738-7893