PROCEDURE/SURGICAL SITE VERIFICATION CHECKLIST

MEDICAL/SURGICAL/RADIOLOGY/DENTAL

RN: Complete 1-6

1. Name_____ 2. DOB _____

3. DOS _____

4. Operating Physician_____

5.Procedure _____

LEFT _____ RIGHT

Anatomic site

6. Verify the presence of the following documents and that all documentation is consistent with proposed procedure and site (mark NA if not applicable):

- ☐ **H&P or SF 600**
- ☐ **Consent for Operation/procedure**
- ☐ **Anesthesia Preop Note**
- ☐ **Perioperative Nursing Note**
- ☐ **Imaging Studies (as indicated)**
- ☐ **Short Medication List (CHCS)**
- ☐ **Labs**

Please attest that the proposed procedure and site are correctly identified:

7. Patient _____ Date & Time_____

8. RN _____ Date & Time_____

9. Anesthesia_____ Date & Time_____

10. Operating Physician/Surgeon_____ Date & Time_____

Notes or comments:

"TIME OUT" _____ _____

Time Provider/RN/Technician

This includes; correct patient, procedure, site, side, position, and special equipment/implants