MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Number, and Edition Date.

REQUIRING DOCUMENT *(Title and Number)*	ISSUANCE DATE
NAVHOSPBREMINST 6000.9B	20 APR 2010
LOCAL FORM TITLE *(Optional)*	
SURGICAL SITE VERIFICATION CHECKLIST	

Initials Verification:

1. _____ I have read the Informed Consent for Surgery and agree that the Patient/Guardian indicated procedure(s), surgical site and side are correct.

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2. _____ Relevant documentation present including:

OR RN ¤ H&P performed within 30 days of DOS
¤ Preoperative Orders
¤ Consent Form (accurate, complete and signed)
Patient verbally confirms:
¤ Identity with two identifiers
¤ Correct side and site
¤ Procedure
¤ Allergies : _____
_____
(List all identified allergies)

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3. _____ Relevant diagnostic tests and images properly labeled and/or displayed
Surgeon (including urine HCG)
Required implants/tissue, devices, and special equipment available
(including correct sizes and expiration date)
Risk of blood loss < 500 ml or 7ml/kg in children or blood products
available if needed
Site / Patient marked with initials of surgeon if applicable
Preoperative Note completed updating changes in patient's condition

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4. _____ Airway and aspiration risk have been assessed.
Anesthesia

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5. Surgical Site Verification Checklist complete and cleared for transport to the operating room.

OR RN Signature: _____ Date: _____

PRACTITIONER'S NAME	PRACTITIONER'S SIGNATURE	DATE
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*	HOSPITAL OR MEDICAL FACILITY	STATUS
	DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
	SPONSOR'S NAME	SSN
	RELATIONSHIP TO SPONSOR	

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