



PERIOPERATIVE CHECKLIST

Date: _____ B#: _____ DOB: _____

Patients Name: _____ Surgeon: _____

Procedure: _____

PRE PROCEDURE CHECKLIST

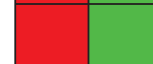
1. Two Patient Identifiers



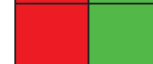
2. Allergies



3. Consent Signed & Verified



4. History & Physical



5. Antibiotics Given: Yes No Redose



6. DVT Prophylaxis



7. Beta Blocker Protocol



8. SURGICAL TIME OUT

* Correct patient Identity



* Correct site and side: Left _____ Right _____



* Procedure to be performed



* Patient Position: _____



* Implant and/ or Special Equipment or Surgical

Requirements: N/A _____ Available _____ In Room _____



*Blood Products: N/A _____ Available _____ In Room _____



Units _____ FFP _____ Platlets _____ O Neg _____

*Radiological Exams: N/A _____ Available _____ In Room _____



POST PROCEDURE CHECKLIST

1. Wound Class



2. FIO₂ Protocol



3. Pathology Specimens Reviewed



4. Blood Tickets Reviewed

