SUNY DOWNSTATE Medical Center
University Hospital of Brooklyn

UNIVERSAL PROTOCOL CHECKLIST

PLACE PATIENT LABEL HERE OR FILL IN

	UNIT #	
PATIENT NAME:		
MEDICAL RECORD #:	DOB:	SEX:
PHYSICIAN SERVICE		

INSTRUCTIONS:

1. All of Section I must be completed.
2. The patient will be held in Pre-Op Unit /other patient care unit until site is marked.
3. Attending physician will mark the site.
4. Contact attending physician for clarification of any discrepancy.
5. After Section I and II are completed, the responsible clinical staff will ensure the checklist is signed.

SECTION I. COMPLETE IN PRE-OP UNIT/OTHER PATIENT CARE UNIT (BEDSIDE PROCEDURE/AMBULATORY CARE/RADIATION ONCOLOGY/ INTERVENTIONAL IMAGING PROCEDURES)

☐ N/A (when not applicable, explain in comments)

Comments: _____

Patient Identification:

☐ ID band checked for name, Medical Record # and DOB (inpatient/OR)
☐ For outpatients, name and DOB is checked
☐ Patient/Parent/Legal Guardian Statement
☐ Patient record reviewed

☐ N/A (when not applicable, explain in comments)

Comments: _____

Verification of Surgical/Procedural/Treatment Site/Side:
☐ Left ☐ Right ☐ N/A (Not applicable)
Procedure: _____

Confirmed by:
☐ Patient statement
☐ OR schedule/Other schedule
☐ Informed consent
☐ Patient record reviewed
☐ Site/Side Marked by Attending physician

Clinical Staff: Print Name: _____ **Signature:** _____, **Date:** _____
MD/DO/PA/NP/RN/Radiation Therapist/Physicist

SECTION II. COMPLETE IN OR SUITE/OTHER PATIENT CARE UNIT (BEDSIDE PROCEDURE/AMBULATORY CARE)

Patient Identification and Site Verification:

☐ ID band checked for name, Medical Record # and DOB (inpatient/OR)
☐ For outpatients, name and DOB is checked
☐ Patient statement
☐ Patient record reviewed
☐ X-ray film/imaging studies (if applicable, confirmed by surgeon and a second physician)

☐ N/A (when not applicable, explain in comments)

Comments: _____

Surgical/Procedural/Treatment Site/Side marked: ☐ Yes ☐ No

Comment if ***NO***: _____

Antibiotic within 1 hour of start time: ☐ Yes ☐ No ☐ NA

Date: _____

Print Name: _____, RN Signature: _____, RN
Print Name: _____, MD(Physician) Signature: _____, MD
Print Name: _____, MD (Anesthesiologist) Signature: _____,Other

TIME OUT PROCESS: The Attending Surgeon/Physician, Anesthesiologist, Scrub personnel, PA, NP, Radiation Therapist, Physicist will pause and review the patient's identity, procedure, treatment site and side, correct position, implant/equipment, if prophylactic antibiotics is needed, immediately prior to the start of the procedure.

Clinical Staff: MD/DO/PA/NP/RN, Physicist, Radiation Therapist	**Print Name**	**Signature**	**Date**	**Time**