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)**

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 Site/Side:

❒ Left ❒ Right ❒ N/A (Not applicable)

Procedure:_____

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

Comments: _____

Confirmed by:

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

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

**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 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:_____, MD

TIME OUT PROCESS: The Attending Surgeon/Physician, Anesthesiologist, Scrub personnel, PA, NP will pause and review the patient's identity, procedure, 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** | **Print Name** | **Signature** | **Date** | **Time** |
|---|---|---|---|---|
| | _____ | _____ | _____ | _____ |



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