

Procedure Verification

I have reviewed the Surgical and Invasive Procedure Checklist, Consent form and Policies [S-19](#) and [C-07](#), and commit to adhere to procedures set forth by University Hospital.

Name – Please PRINT and sign

Date

Return via fax to Medical Staff Services at 315-464-8524

Last revised 06/2015



UPSTATE
UNIVERSITY HOSPITAL
**SURGICAL AND INVASIVE
PROCEDURE CHECKLIST**

Patient Name: _____ MR#: _____

Account #: _____ DOB: _____ Date: _____

SECTION I

Yes NA Pre-Procedural Verification

- Patient Identity Verified*
- Procedure to be performed (site/side/level) confirmed with patient is consistent with consent schedule or order
- Consent(s) and/or orders for procedure are accurate and complete
- H&P present and updated per policy
- Available imaging and/or diagnostic reports are consistent with patient and are relevant to procedure to be performed
- Requested implants, special equipment/requirements are available
- Correct site is marked by proceduralist; or special wristband applied
- Pre-Operative Checklist was reviewed

Procedure: _____

Nurse/Tech Signature: _____ Print Name/Title: _____ Date/Time: _____

This Section - N/A

SECTION II

Yes NA Anesthesia / Pre-Sedation

- Pre-Sedation/Pre-Anesthesia assessment conducted and documented
- Regional Anesthesia General MAC Deep Sedation Moderate Sedation
- Patient Identity Verified*
- Procedure to be performed (site/side/level) confirmed with patient and is consistent with consent and schedule

Anesthesiologist/
Health Care Member Signature: _____ Print Name/Title: _____ Date/Time: _____

Yes NA Anesthesiology Time Out (for procedures performed prior to surgery e.g. regional nerve block, central line, arterial line)

- Correct Patient Correct Procedure Correct site/side/level is marked (if applicable)
- AGREEMENT (participated in TIME-OUT)
- Resident _____ RN _____ CRNA _____ Other _____

Anesthesiologist/
Health Care Member Signature: _____ Print Name/Title: _____ Date/Time: _____

SECTION III

Yes NA TIME-OUT performed immediately prior to procedure before equipment is offered

- Correct Patient
- Correct Procedure (validated with consent)
- Correct site/side/level mark is visible in the operative field or special wrist band applied
- Implants, special equipment/requirements present and verified with: _____
- Imaging studies and relevant documentation present/reviewed and verified by 2nd team member
- Antibiotics administered Start time: _____ Incision time: _____
- AGREEMENT (participated in TIME-OUT)
- Proceduralist _____ RN/Tech _____ Anesthesiologist / CRNA _____
- PA/NP _____ Resident _____ Other _____

Nurse/Tech Signature: _____ Print Name/Title: _____ Date/Time: _____

SECTION IIIa

Yes NA Additional Confirmatory TIME-OUT

- Confirmatory "Time-Out" verifying identity of patient and procedure performed for new proceduralist assuming responsibility for the case and/or patient/site redraped
- For spinal cases in which an intraoperative image was used to determine spinal level, images were reviewed and correlated with intraspinal markers

Nurse/Tech Signature: _____ Print Name/Title: _____ Date/Time: _____

SECTION IV

Yes NA Sign Out

- Proceduralist states aloud final procedure performed
- Specimens labeled with correct patient ID and confirmation of the correct ordered study/studies completed
- Team members review any issues/concerns with management and/or recovery of the patient

Proceduralist Signature: _____ Print Name/Title: _____ Date/Time: _____

RN/Tech Signature: _____ Print Name/Title: _____ Date/Time: _____

*Patient Identity: Patient/Patient representative, when possible, states full name and DOB. The information stated must match the hospital issued ID band.

SECTION IIIa	<p>Yes NA Additional Confirmatory TIME-OUT</p> <p><input type="checkbox"/> <input type="checkbox"/> Confirmatory "Time-Out" verifying identity of patient and procedure performed for new proceduralist assuming responsibility for the case and/or patient/site redraped</p> <p><input type="checkbox"/> <input type="checkbox"/> For spinal cases in which an intraoperative image was used to determine spinal level, images were reviewed and correlated with intraspinal markers</p>
	<p>Nurse/Tech Signature: _____ Print Name/Title: _____ Date/Time: _____</p>

SECTION IIIa	<p>Yes NA Additional Confirmatory TIME-OUT</p> <p><input type="checkbox"/> <input type="checkbox"/> Confirmatory "Time-Out" verifying identity of patient and procedure performed for new proceduralist assuming responsibility for the case and/or patient/site redraped</p> <p><input type="checkbox"/> <input type="checkbox"/> For spinal cases in which an intraoperative image was used to determine spinal level, images were reviewed and correlated with intraspinal markers</p>
	<p>Nurse/Tech Signature: _____ Print Name/Title: _____ Date/Time: _____</p>

SECTION IIIa	<p>Yes NA Additional Confirmatory TIME-OUT</p> <p><input type="checkbox"/> <input type="checkbox"/> Confirmatory "Time-Out" verifying identity of patient and procedure performed for new proceduralist assuming responsibility for the case and/or patient/site redraped</p> <p><input type="checkbox"/> <input type="checkbox"/> For spinal cases in which an intraoperative image was used to determine spinal level, images were reviewed and correlated with intraspinal markers</p>
	<p>Nurse/Tech Signature: _____ Print Name/Title: _____ Date/Time: _____</p>

Discrepancy identified in procedure; procedure stopped:

- Resolution to discrepancy obtained; process continued
- Discrepancy not resolved steps taken:

Notified:

Signature of person completing form: _____ Print Name/Stamp/Title: _____

Date: _____ Time: _____



UPSTATE
UNIVERSITY HOSPITAL
**CONSENT FOR DIAGNOSTIC,
THERAPEUTIC, INVASIVE OR
SURGICAL PROCEDURES**

Patient Name: _____ MR#: _____

Account #: _____ DOB: _____ Date: _____

1. I give permission to the designated practitioner _____
(Attending Physician or other Practitioner)
and the following physician(s) _____
(Specify Additional Physicians, Excluding Residents)
whom are reasonably anticipated by my doctor to be actually involved in the treatment, procedure
or surgery to be performed upon _____ the following procedure or operation:

(state "myself" or name of patient)

(state nature of procedure first in medical terminology then in laymen's terms)

I understand that resident physicians and/or other qualified non-physician practitioners who are not identified above may perform important tasks during the surgery or procedure.

2. The purpose of and the benefit(s) which may be anticipated from the surgery/procedure(s), although not guaranteed, have been explained to me. The main risks and discomforts which may or will result from the surgery/procedure(s) have been explained to me. The consequences of not having this surgery/procedure have also been explained to me.
3. Alternative surgery/procedures, including the alternative of no treatment, have been explained to me along with the potential benefits and risks.
4. In addition to the benefits and risks which are or may be involved in the surgery/procedure(s), I also know that there is always the possibility of unforeseen or unanticipated conditions occurring. If this occurs, I understand that the medical personnel will use their judgment with respect to my care and treatment, which may involve performing additional or different procedures from those stated, or otherwise altering the planned course of action. This may include the **unanticipated** need for blood transfusion **and the use of x-rays or other diagnostic or therapeutic measures**. I authorize them to do so.
5. If applicable, I give permission for:
 - The use of moderate sedation medicines. These medicines are given to temporarily decrease the sensation of pain, produce calmness, and a sense of well being and/or pain relief.
 - The use of deep sedation medicines. These medicines cause brief unconsciousness and are administered by a non-anesthesiologist physician.

I understand that if sedative or analgesic medicines are administered, I will need to be monitored until I am fully awake before being discharged. In addition, I will only be discharged in the care of a responsible adult.

6. If applicable, I consent to the administration of anesthesia and the use of such anesthetics and invasive monitoring as may be deemed advisable in the medical judgment of and under the supervision of an anesthesiologist.
7. I give permission for the disposal of and/or release of any tissue removed to be used for scientific purposes after all necessary diagnostic tests have been completed. I understand that all identifying information will be removed.
8. I give permission for my social security number to be used as required by the FDA Safe Medical Device Act.

9. I have a current **Do Not Resuscitate (DNR)** Order in place. (Check the box) Yes No
If I checked **yes** and have a DNR Order and I am undergoing a procedure requiring moderate sedation and/or services provided by an anesthesiologist.

a. I wish to maintain DNR status during my operation/procedure. (Check the box). Yes No
If Yes, Attending Surgeon or designee must initiate physician to physician communication with Attending Anesthesiologist.

OR

b. I wish to discontinue DNR status during my operation/procedure. I understand that my DNR status will be resumed when I am discharged by the Anesthesiology Service. (Check the box) Yes No

c. Not applicable because I am not having moderate sedation or general anesthesia. N/A

CONTINUED ON BACK →

10. For the purpose of medical education, I understand that my condition or the procedure I will have performed is expected by my doctor to be useful for medical education purposes if it is recorded, either through visual and/or audio means, and I have been provided with a full explanation of how it will be recorded and how it will be used, and, I consent to the photography and/or televising audio and/or visual recording of the procedure to be performed provided my identity is not revealed. Yes No N/A
 If I am not being asked at this time to consent to the photography, and/or televising audio and/or visual recording for the purposes of medical education, I understand that if my doctor determines during the procedure that it will be useful, that the recording may be performed at the direction of my doctor but will not be used for any purpose unless I later give my consent, and if I do not give my consent the recording will be immediately destroyed.
11. I consent to the presence of additional non-hospital staff during my surgery as directed by my attending surgeon or anesthesiologist. This may include manufacturer representatives or technicians.
(List names below)
12. I have been provided with a full opportunity to ask any questions or express any concerns I may have. My questions have been answered and my concerns addressed to my satisfaction. I understand that I may ask for further information and it will be given to me.
13. I have read this entire document and understand its contents. In addition, I have been told that I am free to withdraw any portion of my consent.
14. I have either completed or crossed off and initialed any unacceptable statements above prior to my signing.

 Date Time Signature of Patient Print Name

If consenting party is other than patient:

 Date Time Signature of Consenting Party Relationship to Patient

Consent Form Witness:

 Date Time Signature of Witness Print Name

Person Explaining Procedure:

 Date Time Signature/Title of Attending or other Staff Explaining Procedure Print Name

Proceduralist Verification for invasive or operative procedures

I verify that the patient has been identified. The consent is accurate, complete and signed. I have marked the operative site if applicable and have reviewed pertinent radiographic images. Any images needed for the procedure are available to me in the OR/procedural area. I have checked that any implants, equipment needed to complete the procedure are available. If this is an operative procedure or if anesthesia is planned, the H&P has been done within 30 days and reviewed within the last 24 hours and updated as necessary and I have written a pre-procedural attending note.

 Date Time Proceduralist Signature/Title Print Name

List below all Non University Hospital personnel present in the OR/Procedure Room at the time of surgery/procedure. Inform the patient/patient representative about their presence.

NAME/TITLE

NAME/TITLE

