

**INVASIVE PROCEDURE  
UNIVERSAL PROTOCOL FORM**

Name of Procedure: \_\_\_\_\_

Right     Left     BiLateral     Not Applicable

IMPRINT PATIENT IDENTIFICATION HERE

<b>Pre-Procedure</b> Must be performed prior to start of procedural time out	Patient Identity Confirmed (Must use two ID checks)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Order verified/procedure confirmed	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Current H&P/ Nursing Assessment available	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Not Applicable
	Current med list available	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Not Applicable
	Lab results available (ex. PT, PTT, INR)	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Not Applicable
	Current diagnostic test available	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Not Applicable
	Special equipment/implant available	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Not Applicable
	Safety Precautions/Allergies confirmed	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Pre-op antibiotics given (n/a if not ordered)	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Not Applicable
	Pre-sedation assessment verified (n/a for non-sedation cases) *	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Not Applicable
	Laterality verified with patient/patient representative	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Not Applicable
	Difficult airway or aspiration risk identified	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Not Applicable
	Blood Products Available	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Not Applicable
	Completed by Signature: _____	Date: _____	Time: _____

\* Must include Mallampati and ASA if using sedation



<b>Time Out- Stop All Activities</b> Time out must be performed immediately prior to start of procedure	Patient Identity Confirmed (Must use two ID checks)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Procedure Confirmed	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Informed Consent signed/Matches Order	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Site Marked-Laterality-by physician/proceduralist Right	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Not Applicable	
	Site Marked-Laterality-by physician/proceduralist Left	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Not Applicable	
	Did Patient Participate in Time Out	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Unable to Participate	
	Specimens are identified and labeled appropriately	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	Signature: _____	Time: _____
	All Members of the team participated in the "Time Out" prior to the procedure.	Signature: _____	Time: _____	

<b>Names</b>	Time Out completed by the following (Please list at least 2 names, one being the proceduralist)	
	<b>PRINTED NAME</b>	
	Proceduralist	_____
	PA	_____
	Nurse	_____
	Technologist	_____
	Other	_____

