PRE-OPERATIVE CHECK LIST

Booked for:

Date and Time of Surgery	Surgery Verified	
	Unit	**OR**
Validated by patient	☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA
Site confirmed by patient	☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA
Surgical Consent signed	☐ Yes ☐ No	☐ Yes ☐ No
Blood Product Consent signed	☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA
VTE assessment completed	☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA
ID Band On	☐ Yes ☐ No	☐ Yes ☐ No
Validated by patient	☐ Yes ☐ No	☐ Yes ☐ No

Pertinent History:
History of ARO: ☐ MRSA ☐ VRE ☐ Other *(Specify)*
☐ Diabetes Type 1 ☐ Diabetes Type 2 __IDDM __NIDDM ☐ Bariatric
☐ Malignant Hyperthermia ☐ Previous complications

Allergies: *(Specify)*

	Allergy Verified	
	Unit	**OR**
Latex Allergy	☐ Yes ☐ No	☐ Yes ☐ No
Validated by patient	☐ Yes ☐ No	☐ Yes ☐ No
Allergy band on:	☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA

Medical/Surgical Implants: *(Specify)*

Chart Complete ☐ Yes ☐ No **Old Charts Present** ☐ Yes ☐ No
Addressograph/Printer on chart ☐ Yes ☐ No
Anesthetic Record :BP/P/Resp/SpO_2/Temp/Ht/Wt recorded ☐ Yes ☐ No
Reports on chart:
☐ Medical Imaging *(type)* ☐ Lab ☐ ECG
☐History and Physical ☐ Consultation(s) ☐ Physician Notes
☐ Admission Assessment and History ☐ Care Plan ☐ Notes

Personal Valuables Secured:
Jewelry ☐ Yes *secured where*________________ ☐ No
Piercings ☐ Yes *secured where*________________ ☐ No
Valuables ☐ Yes *secured where*________________ ☐ No
List valuables secured:

Pre-Op Teaching Done: ☐ Yes ☐ No

Physical/Intellectual Challenges: *(List)*

Health Care Directives *(describe)* Copies on chart ☐ Yes *(If yes, check boxes)* ☐ No
☐ Living Will ☐ Advanced Directive ☐ Feeding Restrictions ☐ Medication Restrictions ☐ Blood Product Restrictions
☐ Other Restrictions *(Specify)*
☐ Power of Attorney/Medical Proxy in place ☐ Palliative Care ☐ Organ Donation ☐ Autopsy Request

Criteria	Unit Verified			OR Verified			Criteria	Unit Verified			OR Verified		
	Yes	No	NA	Yes	No	NA		Yes	No	NA	Yes	No	NA
Bath/Shower/Scrub							Make up removed						
Hair Clipped Date Time							Polish/Artificial Nails removed						
Personal Clothing and underwear removed							Dentures/Partial/Retainer removed						
Glasses/contacts removed							Hearing aid Lt removed						
Pins/Hairclips removed							Hearing aid Rt removed						
Tampon removed							Prosthesis removed						
Bowel Prep done							Voided at						
NG Tube inserted Size							Catheter inserted Type Size						
NPO – Solids at							Medications taken this am						
NPO Clear Fluids at							Pre-Op medications given						
IV Site checked							Medications to OR						
Blood Products arranged							Antiembolic Stockings						
Pre-Op Teaching done							ICU Bed arranged						

Mobility Needs: ☐ Bedridden ☐ Crutches☐ Walking ☐ Carry ☐ Hospital Bed ☐ Wheelchair ☐ Chair ☐ Incubator ☐ Crib ☐ Stretcher ☐ Unknown

Base Line Vital Signs	BP	Pulse	Resp	SpO_2	Temp	B G	Pain *(0-10)*	Ht	Wt

IV #1 of ________________________at __________
Site______________

IV #2 of ____________________at __________ Site________________

Unit
Transfer Date ________________Time__________________
Pre-Op checklist reviewed with OR Nurse: ☐ Yes ☐ No

Signature of Unit Nurse

OR
Arrival Date _____________________Time__________________
Pre-Op Checklist received with Unit Nurse: ☐ Yes ☐ No

Signature of OR Nurse

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