PRE PROCEDURE CHECK LIST
(Please check the boxes or fill in the blanks where appropriate)
Any "No" response requires a note

A) PROCEDURE: ______________________

ISOLATION PRECAUTIONS ☐ Yes Type: __________
If yes, must call pre-op, ext. 83459

Spoke to: ______________ Time: __________

Preferred language: ______________

B) REQUIRED LAB WORK / STUDIES COMPLETED:

CBC/PA/LP (within 14 days) ☐ Yes ☐ No ☐ Abnormal ☐ Physician Called
Urinalysis ☐ Yes ☐ No ☐ Abnormal ☐ Physician Called
Chest X-Ray ☐ Yes ☐ No ☐ Abnormal ☐ Physician Called
EKG (greater than 49 years; within 30 days) ☐ Yes ☐ No ☐ Abnormal ☐ Physician Called
HCG (females less than 55 years) ☐ Yes ☐ No ☐ Abnormal ☐ Physician Called
PT/PTT/INR ☐ Yes ☐ No ☐ Abnormal ☐ Physician Called
MRSA Swab completed ☐ Yes ☐ No

On Anticoagulants: ☐ Yes ☐ No Stop Date: __________

Type & Screen: Expires: ______________ ☐ N/A
(See notes section on reverse for abnormal labs)

C) CHART REQUIREMENTS:

History & Physical On Chart ☐ Yes ☐ No, Physician Notified
History & Physical Update ☐ Yes ☐ No ☐ N/A
Medical Consult ☐ Yes ☐ No ☐ N/A
Old Records Sent to OR ☐ Yes ☐ No ☐ N/A
Anesthesia Assessment ☐ Yes ☐ No ☐ N/A

Consent Signed:	By Patient	By Physician
Procedural	☐ Yes ☐ No	☐ Yes ☐ No
Transfusion Preference: ☐ Do ☐ Do Not	☐ Yes ☐ No	
Anesthesia	☐ Yes ☐ No	☐ Yes ☐ No
Imaging Studies:	☐ Yes ☐ No ☐ N/A	

Initiated By
(Signature & Title): ______________

SURGICAL CARE IMPROVEMENT PROJECT

- Beta Blocker ☐ Yes ☐ No ☐ N/A
  Last dose (date / time)__________
- Anticoagulant ☐ Yes ☐ No ☐ N/A
  Last dose (date / time)__________
- Antibiotic ordered specific to procedure
  ☐ Yes ☐ No ☐ N/A
- SCD's / TED's ordered
  ☐ Yes ☐ No ☐ N/A

D) PATIENT PREPARATION: (To begin on call to OR)

Patient Verbalizes:
Surgeon's Name ☐ Yes ☐ No Procedure ☐ Yes ☐ No

Nothing by mouth after midnight ☐ Yes ☐ No Time: ______

Mental Status: ______________
Patient Identified ☐ Yes ☐ No
ID Band ☐ Yes ☐ No
Voided Pre-Op ☐ Yes ☐ Foley Other: __________

Allergies: ______________
Allergy Band: ☐ Yes ☐ No
Blood Band: ☐ Yes ☐ No

IV: Gauge: ______ Site: ______ Date: ______

☐ Diabetic ☐ Yes ☐ No Last Blood Sugar: ______ at ______

VITAL SIGNS: Time: ______
Blood Pressure (BP): ______ Temperature(T): ______

Pulse(P): ______ Respiration(R): ______

Oxygen Saturation By Pulse Oximeter (SPO_2): ______
Abnormal results called to physician? ☐ Yes ☐ No

Physician name: ______________

E) PERSONAL EFFECTS REMOVED

Dentures	☐ Removed	☐ Left in	☐ N/A
Glasses / Contacts	☐ Removed	☐ Left in	☐ N/A
Jewelry (including body piercings)	☐ Removed	☐ Left in	☐ N/A
Hearing Aid	☐ Removed	☐ Left in	☐ N/A
Nail Polish	☐ Removed	☐ Left on	☐ N/A
Prosthesis	☐ Removed	☐ Left in	☐ N/A
Clothing	☐ Removed	☐ Left on	☐ N/A

☐ Other: ______________

Location of belongings: ______________

F) REPORT:

To Holding Area at ______ via ☐ Bed ☐ Stretcher

Report called to: ______________ at ______

G) ACCOMPANYING ADULT: The person my surgeon may speak with following my procedure is: ______________

Phone: __________ Location: __________

The above adult will be responsible to take me home following my procedure if I am discharged on the same day. ☐ N/A
Completed & Verified
By (Signature & Title): ______________

Dat

Date: ________ Time: ________

JFK MEDICAL CENTER NORTH CAMPUS
WEST PALM BEACH, FL 33407
PRE PROCEDURE CHECK LIST

Dat

Dat

Evening Call Notes: ____________________

Completed By (Signature and Title): ____________________ Date: __________ Time: __________

Notes: ____________________

Completed By (Signature and Title): ____________________ Date: __________ Time: __________