

To be completed 24 hours prior to surgery

DATE:

* CALL REPORT AT 4474 (6 AM - 6 PM)
CALL REPORT AT 6171 (6 PM - 6 AM & weekends & holidays)

INSTRUCTIONS: Indicate that the task has been completed or the proper form is on the chart by initializing the item. Place NA in the column if item does not apply. Sign full name and title at bottom of page. Complete new form for each surgery procedure date.

REVIEW MEDICAL RECORD AND PHYSICIAN'S ORDER:	INITIALS
1. History and Physical completed and in chart	1. _____
2. Laboratory studies/Reports in chart	2. _____
3. EKG report in chart	3. _____
4. Chest X-ray report in chart	4. _____
5. Operative Permit completed, signed, & witnessed in chart	5. _____
<input type="checkbox"/> Patient Affirmation <input type="checkbox"/> Witness Affirmation <input type="checkbox"/> Physician Attestation	
6. Anesthesia Permit completed, signed, & witnessed in chart	6. _____
<input type="checkbox"/> Patient Affirmation <input type="checkbox"/> Witness Affirmation <input type="checkbox"/> Physician Attestation	
7. Consent for blood transfusion completed, signed, & witnessed in chart	7. _____
<input type="checkbox"/> Patient Affirmation <input type="checkbox"/> Witness Affirmation <input type="checkbox"/> Physician Attestation	
8. Medication Reconciliation Form Completed & Signed	8. _____
9. 4 pages of labels	9. _____

PREOPERATIVE PREPARATION:	INITIALS
1. Identification bracelet accurate and affixed to wrist or ankle prior to transport	1. _____
2. Allergies checked, allergies bracelet on and allergy sticker on chart	2. _____
3. Isolation label on chart	3. _____
4. Jewelry, hairpieces, hairpins, contact lenses, glasses, prosthesis, underwear, money removed ..	4. _____
5. Vital signs taken and recorded	5. _____
Time taken _____ BP _____ Temp _____ HR _____ Resp _____ FS _____	6. _____
6. Dentures: <input type="checkbox"/> Full: <input type="checkbox"/> Upper <input type="checkbox"/> Lower <input type="checkbox"/> Partial: <input type="checkbox"/> Upper <input type="checkbox"/> Lower	
<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Removed: <input type="checkbox"/> Sent Home <input type="checkbox"/> Left at bedside	
<input type="checkbox"/> Left in place as requested by: <input type="checkbox"/> Anesthesiologist <input type="checkbox"/> Patient	
7. Patient NPO <input type="checkbox"/> yes since _____ <input type="checkbox"/> no	7. _____
If no: O.R. notified (Time) _____ (Whom)	
8. Medication sheets on chart.....	8. _____
9. Most recent nursing assessment attached.....	9. _____
10. Report called to _____ at _____ (time)	10. _____

INITIALS	SIGNATURE AND TITLE	INITIALS	SIGNATURE AND TITLE

THE GEORGE WASHINGTON UNIVERSITY HOSPITAL



NURSING PREOPERATIVE CHECKLIST

75-041 (12/06)

Patient Label

2-Hole 1/4 2 3/4 - 3-Hole 1/4 4 1/4