TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER™
EL PASO

Department of _____ Patient Name:
UNIVERSAL PROTOCOL CHECKLIST DOB: or visit label
E#

Universal Protocol:

- Applies to procedures that expose the patient to more than minimal risk of harm, require site marking, or are of such complexity that Universal Protocol applies.

TIME OUT:

- Conducted prior to starting procedure and involves ALL participants in the procedure.

Date and Time: _____

Patient Name: _____

Patient Identified: (circle two identifiers used) **Name / DOB / other _____**

Procedure:_____ Site:_____Right_____Left ____Central____

Procedure:_____ Site:_____Right_____Left ____Central____

Procedure:_____ Site:_____Right_____Left ____Central____

Procedure:_____ Site:_____Right_____Left ____Central____

Appropriate Consent(s) completed and signed: Yes / No

Site(s) initialed by Care Provider performing procedure: Yes / No / NA

Necessary documentation, diagnostic and radiology test results available Yes / No / NA

High risk and or procedures requiring moderate or deep sedation require relevant documentation within 30 days prior to procedure.

° H&P on chart Yes ☐ No ☐

Necessary equipment reviewed, assembled, available and sterile (if applicable): Yes / No

Team Members: _____

All Team Members in Agreement?: ☐ Yes ☐ No

Name of person completing this form: _____ Signature_____