

Department of ___

UNIVERSAL PROTOCOL CHECKLIST	DOB: E#	or visit	or visit label		
Universal Protocol:	L#				
Applies to procedures that exposing marking, or are of such complex			risk of h	arm, require site	
TIME OUT: • Conducted prior to starting process.	edure and invol	ves ALL participants	in the p	rocedure.	
Date and Time:				_	
Patient Name:				_	
Patient Identified: (circle two identifiers used) Na	me / DOB / othe	r		
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 sign	ied: Yes / No				
Site(s) initialed by Care Provider performing	g procedure: Ye	es / No / NA			
Necessary documentation, diagnostic and r	adiology test res	sults available Yes / No	/ NA		
High risk and or procedures requiring moderate prior to procedure.	or deep sedation	require relevant docume	ntation w	ithin 30 days	
° H&P on chart Yes No No					
Necessary equipment reviewed, assembled	l, available and s	terile (if applicable): Yo	es / No		
Team Members:					
All Team Members in Agreement?: ☐ Yes □	□No				
Name of person completing this form:	ne of person completing this form: Signature				

Patient Name: