**Planned Procedure:** ___________________________________________________  
_____________________________________________________________________

**Date of Procedure:** _________________________________________________

**COMPONENT # 1 VERIFICATION PROCESS**

<table>
<thead>
<tr>
<th>Mark all that apply <strong>indicates required field</strong></th>
<th>Sending Unit</th>
<th>Prep &amp; Holding</th>
<th>Unit Doing Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name and date of birth confirmed **</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient/Decision maker verbalizes planned procedure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schedule confirms planned procedure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consent confirms planned procedure **</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>History and Physical confirms planned procedure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic Study confirms planned procedure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Progress Record/Consult confirms planned procedure</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Site marking required (go to Component 2)  
Site marking not required

Date/Time: ____________________  
Initial: ____________________

**COMPONENT # 3 TIME OUT**

The entire procedure team has performed a Time Out and all members have verbally agreed.

Time out included the verification of:  
1<sup>st</sup> 2<sup>nd</sup> 3<sup>rd</sup>

| 1<sup>st</sup> Time Out: Time:_________ Initial:_________ |
| 2<sup>nd</sup> Time Out: Time:_________ Initial:_________ |
| 3<sup>rd</sup> Time Out: Time:_________ Initial:_________ |

**COMPONENT # 2 SITE MARKING (If required)**

After verification has been completed, the patient if able, will write "Yes" with a permanent marker on or as near the site as possible:

- RIGHT ____________________  
- LEFT ____________________

Side marked by:

- Patient  
- Family member (Relationship):____________  
- Healthcare Provider

Initial:______________________  
Time:______________________

**FIRE RISK ASSESSMENT**

| Procedure site or incision above the xiphoid | 1 (Yes) 0 (NO) |
| Open oxygen source (face mask/ nasal cannula) | 1 (Yes) 0 (NO) |
| Ignition source (cautery, laser, fiberoptic light source) | 1 (Yes) 0 (NO) |

SCORE 1 or 2:  
- Initiate Routine Protocol
SCORE 3:  
- Initiate High Risk Fire Protocol  
(see side 2 for specifics)

Initial:_________  
Time:_________

**Total Score:**  
_______
COMPONENT #1 VERIFICATION PROCESS
Purpose: To outline the process for identifying the correct person, correct procedure, and correct site for surgical and invasive procedures with involvement of the patient or decision maker when possible.

A. The caregiver (RN/LPN, anesthesia provider, surgeon, resident, PA) beginning the verification process will initiate the form.
B. When care of the patient is transferred to a new care area, the new care giver will complete the appropriate columns and initial.
C. Mark (✓) only the boxes that indicate the method reviewed to confirm the planned procedure.
D. Resolve discrepancies identified through the verification process prior to moving the patient to the procedure area or prior to the initiation of the bedside procedure/anesthesia regional block.

COMPONENT #2 SITE MARKING
Purpose: To clearly identify the intended site of incision or insertion.

A. Document site marking for patients having surgical/invasive procedures involving laterality or digits. (Patients having surgical/invasive procedures involving level(s) (i.e. spine or ribs) will have level(s) marked by the Licensed Independent Practitioner (LIP) performing the procedure or identified by the LIP using radiographic techniques during the procedure.)

COMPONENT #3 TIMEOUT
Purpose: To conduct a final verification of the correct patient, procedure, site and implants, if applicable.

A. Time out is completed prior to the start of the procedure and a designated person (circulating RN, assisting RN or tech) will complete the section and initial.
B. Mark (✓) only the boxes that indicate the components confirmed.
C. An additional Time Out is documented for a second procedure.
D. In the event that the physician performing the procedure leaves the patient or repositions the patient after the Time Out process has occurred, the Time Out process is repeated and documented.

FIRE RISK ASSESSMENT
• Routine Protocol
  1. FUEL:
     A. When an alcohol based solution is used, use minimal amount of solution and allow sufficient time for fumes to dissipate before draping. Observe drying time (minimum 3 minutes). Do not drape patient until flammable prep is fully dry.
     B. Do not allow pooling of any prep solution (including under the patient).
     C. Remove bowls of volatile solution from sterile filed as soon as possible after use.
     D. Utilize standard draping procedure
  2. IGNITION SOURCE:
     A. Protect all heat sources when not in use. (cautery pencil holster, laser in stand by mode etc.)
     B. Activate heat source only when active tip is in line of sight.
     C. De-activate heat sources before tip leaves surgical site.
     D. Check all electrical equipment before use.
• High Risk Protocol (includes all of routine protocol)
  A. Use appropriate draping techniques to minimize O₂ concentration (i.e., tenting, incise drape).
  B. Electrical Surgical Unit (ESU) setting should be minimized
  C. Encourage use of wet sponges.
  D. Basin of sterile saline and bulb syringe available for suppression purposes only.
  E. Anesthesia Care Provider considerations:
     • A syringe full of saline will be available, in reach of the anesthesia care provider, for procedures within the oral cavity.
     • Documentation of oxygen concentration/flows. Use of “MAC Circuit” for oxygen administration.