TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER™
From here, it's possible.

El Paso Campus
Department of _____
UNIVERSAL PROTOCOL CHECKLIST

Patient Name:
DOB: or visit label
MR#

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 / NA

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: ☐

Signature of person completing this form: _____