**PT STICKER**

 **OPHTHALMOLOGY SURGICAL SAFETY CHECKLIST**

 **(with nurse and anesthesia provider) (with nurse, anesthesia, surgeon, technician) (with nurse, anesthetist and surgeon)**

**TIME OUT**

**Before patient leaves operating room**

 **Before incision**

 **Before anesthesia**

**Confirm:**

**□ Full patient name, DOB**

**□ Side**

**□ Procedure**

**□ Lens verification (comparison of orders with physician chart calculations)**

**□ Consent**

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**Is the site marked correctly?**

**□ Yes □ Not applicable**

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**Are the patient monitors/anesthesia machine and medication check complete?**

**□ Yes**

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**Known allergy?**

**□ No □ Yes**

**Difficult airway or aspiration risk?**

**□ No □ Yes, and equipment/assistance**

 **Available**

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**□ Confirmation of availability of proposed implants**

 **(IOL, shunts, tissue, etc.)**

**□ Confirmation availability of special**

 **Medications**

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 **(Pre-Op RN Signature)**

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 **(Signature of Nurse)**

**Nurse Verbally Confirms:**

**□ The name of the procedure**

**□ Lens label on patient record**

**□ Specimen labeling (read specimen labels**

 **aloud, including patient name)**

 **□ N/A**

**□ Equipment problems addressed**

 **□ N/A**

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**To Surgeon, Anesthetist and Nurse:**

**□ Concerns for recovery to be communicated**

 **with PACU \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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 **(Signature of Circulator)**

**□ Confirm all team members introduce themselves by name and role, if unfamiliar to each other.**

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**□ Confirm the patient’s name, procedure, and where the incision will be made.**

**□ Lens verification (comparison of orders with physician chart calculations)**

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**Has IV antibiotic prophylaxis been given within the last 60 minutes? □ Yes □ No □ Not applicable**

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**Anticipated Critical Events**

**To Surgeon:**

**□ Are there any critical or non-routine steps?**

**To Anesthetist:**

**□ Are there any patient-specific concerns?**

**□ Allergy confirmation**

**To Nursing Team:**

**□ Has sterility (including indicator results) been con-**

 **firmed?**

**□ Are there equipment issues or any concerns?**

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**□ Confirmation of availability of proposed implants**

 **(IOL, shunts, tissue, etc.).**

**□ Confirmation of availability of special medications**

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 **(Signature of Circulator)**