Patient Safety Authority

Two-Person Patient Verification Form

Name: _____

DOB: _____

Exam: _____

Laterality: ☐Yes ☐N/A

Site/Laterality Marked: ☐Yes

Pregnant: ☐Yes ☐No ☐N/A

CT Scan Studies Only

IV Contrast Order: ☐Yes ☐No

Verified Contrast Expiration Date: ☐Yes ☐No

Patient Safety Flow Sheet (If IV Contrast Used): ☐Yes ☐No

Tech/Title: _____ Signature: _____

Witness/Title: _____ Signature: _____

No Witness Available: _____

(Print Assigned Nurse or Head Nurse Name)

Reprinted with permission from NYC Health + Hospitals/Lincoln, Bronx, New York.