

# Day of Surgery

Today's Date: / /



An Independent Agency of the Commonwealth of Pennsylvania

## WRITE LEGIBLY AND DO NOT USE ABBREVIATIONS

### Standardized Independent Verification #2

Patient First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
 #1 Identifier: \_\_\_\_\_ #2 Identifier: \_\_\_\_\_  
 Surgeon Name: \_\_\_\_\_ Date of Surgery: \_\_\_\_\_  
 Procedure to Be Performed: \_\_\_\_\_ Secondary Procedure: \_\_\_\_\_

Patient Information	Medical Documentation	Surgical Information	Information Verified By
<ul style="list-style-type: none"> <li>Surgical consent states complete procedure (circle one): Yes / No</li> <li>Surgical consent identifies (check one):  <input type="checkbox"/> Left  <input type="checkbox"/> Right  <input type="checkbox"/> Bilateral  <input type="checkbox"/> N/A</li> <li>Patient fully conscious during verification of procedure (circle one): Yes / No</li> <li>Patient or patient's legal representative verbalizes correct procedure (circle one): Yes / No</li> <li>Patient or patient's legal representative verbalizes correct site/ side (circle one): Yes / No</li> </ul>	<ul style="list-style-type: none"> <li>History and physical (H &amp; P) attached (circle one): Yes / No</li> <li>History and physical identifies side (check one):  <input type="checkbox"/> Left  <input type="checkbox"/> Right  <input type="checkbox"/> Bilateral  <input type="checkbox"/> N/A</li> <li>Pathology/laboratory studies attached (circle one): Yes / No</li> <li>Radiologic studies attached (circle one): Yes / No</li> <li>EKG (circle one): Yes / No</li> <li>Other tests attached: _____</li> <li>Anesthesia consent and interview completed (circle one): Yes / No</li> <li>Physician's orders attached (circle one): Yes / No</li> </ul>	<ul style="list-style-type: none"> <li>Surgical procedure verified with all other documents (check one):  <input type="checkbox"/> Schedule  <input type="checkbox"/> Consent  <input type="checkbox"/> H &amp; P</li> <li>Surgical side (check one):  <input type="checkbox"/> Left  <input type="checkbox"/> Right  <input type="checkbox"/> Bilateral  <input type="checkbox"/> N/A</li> <li>Surgical site verified (circle one): Yes / No</li> <li>Surgical position verified (circle one): Yes / No</li> <li>Implants/ other instrumentation verified (circle one): Yes / No</li> <li>Positioning device required (circle one): Yes / No If Yes, specify: _____</li> </ul>	<ul style="list-style-type: none"> <li>Name (please print): _____</li> <li>Signature: _____</li> <li>Date and time information recorded and verified: _____/_____/_____ _____ (Time)</li> </ul>

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For more information, visit

<http://www.patientsafetyauthority.org>



Pennsylvania Patient Safety Reporting System