SSMHealth
CardinalGlennon
Children's Hospital

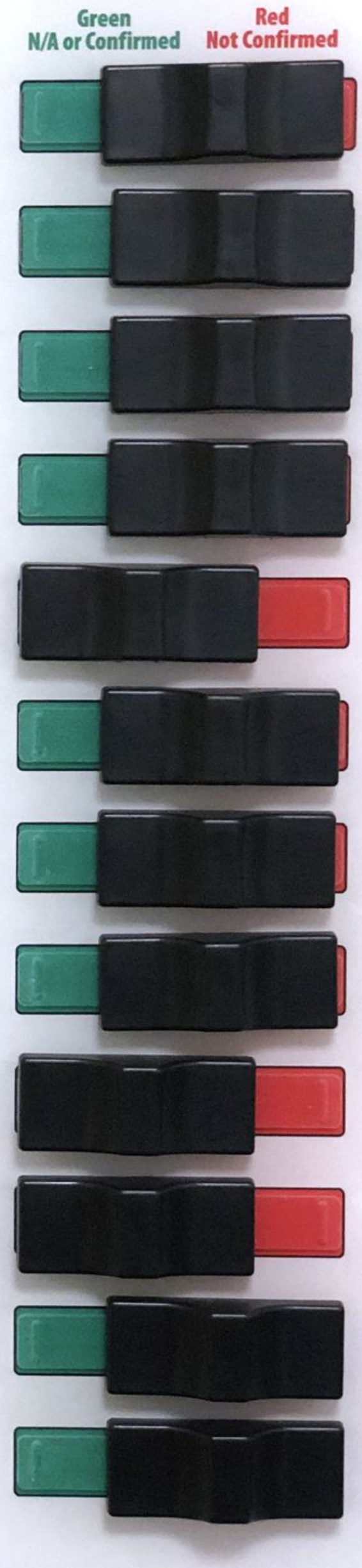
Emergency Department Time Out Checklist

Patient Name_____ **DOB**_____

MRN#_____ **Wt/Kg**_____

Procedure _____

All Items must be confirmed by 2 Team Members



1. **All Team Members Present at Bedside**
2. **Patient Identified / Verified with Armband Using 3 Identifiers**
3. **Procedure Confirmed**
4. **Consent Completed and Signed Time, Date & Laterality included**
5. **H & P Verified**
6. **Site Marked / Visible Correct Patient Position**
7. **Diagnostics / Images – Available (if applicable)**
8. **Safety Precautions Reviewed**
9. **Allergies**_____
10. **Antibiotics / Medications / Equipment Available**_____
11. **Pt / Family questions or concerns addressed**
12. **Sedation Discharge Instructions in AVS**

■ = Physician ■ = Team

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