

Patient Name

Patient ID

Date of Birth

Male Female

Ward:

Referring Physician

CIRSE IR Patient Safety Checklist*



Procedure:

Date:

Cardiovascular and Interventional Radiological Society of Europe

PROCEDURE PLANNING	YES	NO	N/A
Discussed referring Physician/MDT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Imaging Sss Reviewed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relevant Medical History	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Informed Consent	<input type="checkbox"/>	<input type="checkbox"/>	
CIN Prophylaxis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specific Tools Present/Ordered	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fasting Order Given	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relevant Lab Tests Ordered	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anaesthesiologist Necessary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anticoagulant Medication Stopped	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Postinterventional (ICU) Bed Required	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contrast Allergy Prophylaxis Necessary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SIGN IN	YES	NO	N/A
All team members introduced	<input type="checkbox"/>	<input type="checkbox"/>	
All Records with Patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Correct patient/side/site	<input type="checkbox"/>	<input type="checkbox"/>	
Patient Fasting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IV Access	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Monitoring Equipment Attached	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coagulation screen/Lab Tests checked	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies and/or Phrophylaxis Checked	<input type="checkbox"/>	<input type="checkbox"/>	
Antibiotics/other drugs administered	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Consent/Complications Discussed	<input type="checkbox"/>	<input type="checkbox"/>	

SIGN OUT	YES	NO	N/A
Post-op Note Written	<input type="checkbox"/>	<input type="checkbox"/>	
Vital signs normal during procedure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication and CM Recorded	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lab Tests Ordered	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All Samples Labelled and Sent to Lab	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Procedure Results discussed with Patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post-discharge instruction given	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Follow-up tests/imaging ordered	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Follow-up OPD appointment made	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Procedure results communicated to referrer	<input type="checkbox"/>	<input type="checkbox"/>	

Name:

Signature: _____

Name:

Signature: _____

Name:

Signature: _____

* Modified from RADPASS & WHO SURGICAL CHECKLIST