PRE-OPERATIVE CHECKLIST

NAME :
DATE OF BIRTH : SEX :
ADMIT DATE : ROOM NO. :
MRN : EPISODE NO. :

SURGEON : ANAESTHETIST : DATE:

DRUG ALLERGY: TYPE OF OPERATION:

PLEASE (✓)

	Ward Nurse		Theatre Nurse		REMARKS
	YES	NO	YES	NO	
Identification bracelet checked					
Fasted from ____ Hrs on / /					
Consent taken / signed					
O.T. attire					
Shaving done					
Bowel preparation done					
Bladder emptied					
Dentures Upper / Lower					Kept By :
Valuables / Jewellery / Contact lens removed					Kept By :
Nail varnish / hair clips removed					
IV Fluid(s) / infusion(s)					
Pre-Medication given @ _____ Hrs					
Prescription Chart(s)					
Case notes/Old notes					
X-Rays / CT / MRI /Angio Films					
Patient's belonging to ICU / In Ward					

INVESTIGATIONS DONE:					With Dr.	
Blood tests						REMARKS
Group and cross match						
E.C.G.						
X'Rays /CT / MRI / Angio Films						
Biohazards / Infectious Disease						
CTG						
Others						
NURSE'S INITIALS						