



HOSPITAL SULTAN ABDUL AZIZ SHAH
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RADIOLOGY PRE-PROCEDURE CHECKLIST

(Kindly stick patient sticker)	WARD	:
	DIAGNOSIS	:
	PROCEDURE	:
	DATE & TIME ARRIVED	:

Please tick (/) and circle the appropriate columns:

NO.	DESCRIPTION	WARD NURSE			RECEIVING NURSE			REMARKS
		YES	NO	N/A	YES	NO	N/A	
1.	Patient Identification (Wrist band)							
2.	Type of Anaesthesia	GA/LA/Sedation			GA/LA/Sedation			
3.	Consent :-							
	• Procedure							
	• Anaesthesia							
	• Contrast							
	• Blood Transfusion							
4.	Case Notes							
5.	Medication Chart							
6.	Procedure Site Marking							
7.	Medical Illness / Allergies							Specify :
8.	Infectious Disease							Specify :
9..	Skin Preparation							Specify :
10.	NBM (NIL by mouth)							Last meal at: _____Hrs
11.	Pre-medication							Refer Medication Chart (if indicated)
12.	Last Menstrual Period (LMP)							Date :

NO.	DESCRIPTION	WARD NURSE			RECEIVING NURSE			REMARKS	
		YES	NO	N/A	YES	NO	N/A		
13.	Urinary :- <ul style="list-style-type: none"> • CBD • Empty Bladder 							Date of insertion : Size	
14.	Blood Investigation Results :-								
	<ul style="list-style-type: none"> • 12 Lead ECG 								
	<ul style="list-style-type: none"> • GXM/GSH 								
	<ul style="list-style-type: none"> • FBC/RP/LFT 								
	<ul style="list-style-type: none"> • PT/PTT/INR 								
14.	<ul style="list-style-type: none"> • Imaging 								
	<p>Remove all jewellery, contact lens, make-up, nail varnish, dentures, hearing aids and prosthesis (if any) Undergarments - Ensure OT gown and cap from ward</p>								
	16. IV Cannula/PICC/CVL/IJC/Chemoport/Fistula							Site :	
	17. Drainage (if any)							Site :	
	18. Morse Fall Risk Score (High/Medium/Low)	H	M	L	H	M	L		
19.	Vital Signs	Time : ____ Hrs B/P : ____ mmHg PR : ____ bpm RR : ____ Temp: ____ °C SPO2: ____ Pain Score : ____/10 DXT : ____ mmol/L			Time : ____ Hrs B/P : ____ mmHg PR : ____ bpm RR : ____ Temp: ____ °C SPO2: ____ Pain Score : ____/10 DXT : ____ mmol/L				
20.	Post Procedure Admission :- <ul style="list-style-type: none"> • Ward • ICU • PACU 								
21.	Family/Next-of-kin							Contact No:	
<p style="text-align: center;">FOR WARD USE</p> Checked by : (Ward Nurse) Signature : Name & Official Stamp : Date : Time :					<p style="text-align: center;">FOR RADIOLOGY USE</p> Checked by : Signature : Name & Official Stamp : Date : Time :				