Pre-Operative Site Marking Verification

Patient Details (Addressograph Label)

Name:

HCRN:

DOB:

Date of Procedure:

The operating surgeon or nominated deputy who will be present in the theatre at the time of the patient's procedure, signs to confirm that the site is marked and patient identity is checked

- **Patients identity, name, Date of Birth, Address and Health Care Record Number checked** ☐

- **Consent form checked that indicates correct procedure and side** ☐

- **Site/side/digit/level confirmed in medical record (*or with imaging if appropriate*) and marked with indelible ink** ☐

Doctor's Name (PRINT):

Doctor's Signature:

IMC: **Bleep No.:**

Date: **Time:**

Mobile No. (If used):