



**Rhode Island Hospital**

*A Lifespan Partner*

**PROCEDURE NOTE**

Invasive Procedure Outside of the Operating Room

*No Sedation Required*

Addressograph Only

**Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_ **Location:**  Inpatient Unit: \_\_\_\_\_

Procedural Area:

Adult ED  Hasbro ED  Other: \_\_\_\_\_

**PLANNED PROCEDURE:** \_\_\_\_\_

**DIAGNOSIS/INDICATION:** \_\_\_\_\_

**IMMEDIATE PRE-PROCEDURE "TIME OUT"**

Please **STOP** here!

Complete an *Invasive Procedure Verification Checklist* form\* to document confirmation of correct patient, procedure, and site prior to performance of this invasive procedure on this patient.

**-----IMMEDIATE POST-PROCEDURE NOTE-----**

**PROCEDURE PERFORMED:** \_\_\_\_\_

Check here if excisional debridement done.

**LOCAL ANESTHETIC:** \_\_\_\_\_ **Dose:** \_\_\_\_\_

**POST-PROCEDURE DIAGNOSIS:** \_\_\_\_\_

**FINDINGS:** \_\_\_\_\_

**SPECIMEN(S) / STUDIES, if applicable:** \_\_\_\_\_

**COMPLICATIONS:** \_\_\_\_\_

**PATIENT CONDITION:** \_\_\_\_\_

Follow-up X-ray ordered if appropriate

**Procedure performed by** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

**Print Name** \_\_\_\_\_ **PGY** \_\_\_\_\_ **Page/phone:** \_\_\_\_\_

**Assisted by** \_\_\_\_\_ **Print Name** \_\_\_\_\_