Operating Room Checklist

Date		**Medical Record Number**	
Lastname, Name			
D.O.B.		**Weight (kg)**	
Procedure			
ICG contraindications	Iodine allergies ☐ Mercury allergies ☐ Pregnancy ☐ Lactation ☐		

ICG TIME-OUT

	Yes	No
Confirmed patient identity	☐	☐
Is this a pediatric case	☐	☐
Confirmed procedure	☐	☐
NIR device in room	☐	☐
Device ready for recording including images and video	☐	☐
Sterile covers available for intended device	☐	☐
ICG dye in room	☐	☐
Confirmed ICG dosage	☐	☐
Further dilution required	☐	☐
Sterile water readily available for reconstitution *AND* flushing	☐	☐
Confirm site of administration (e.g.: Peripheral, intradermal, etc)	☐	☐
Industry contacts available in case of device/dye troubleshoot	☐	☐
Verbal confirmation for administration prior to local analgesia administration	☐	☐
Anaesthesia confirmed	☐	☐
Special considerations/Additional comments		