V	YCKOH		MRN		M 37v	, <b>,</b> ,
Wy	ckoff Heights Medical Center	NewYork-Presbyterian Healthcare System  Attitute: Welf Medical College, of Comel University		Inpatient	11-29-22 5	゚゚゚゚゚゚゚゚゚゚゚゚゚゚゚゚゚゚゚゚゚゚゚゚゚゚゚゚゚゚゚゚゚゚゚゚゚゚
	•	•	ACC:			100
	374 Stockholm Street,	Brooklyn, New York 11237				5 (6/4
	CON	ISENT				
D		PERATION. ANESTHESIA,	\natheref{y}			
		NTS OR PROCEDURES	N.			
			`		•	
	DEDIMONION ODANT	ED I avend avendenien in	WHMC			or his/he
1.		ED I grant my permission to ar assistants at Wyckoff Heights M		erform on the Pa	atient named al	
	Perip	herrally insended	Central	calle	ten p	ricc)
		(Ira	11-renthor			
2.	NATURE PURPOSE.	BENEFITS AND ALTERNATIVES	HAVE BEEN EXP	PLAINED The D	hvsician has ex	xplained to me th
		or procedure and the reasons why				•
		the operation or procedure and		of any possib	ole alternatives	to the propose
_	100000000000000000000000000000000000000	e risks & benefits of those alternat		:	a Aliat Alaana and	toin rials as
3.		ATIONS HAVE BEEN EXPLAINING which may occur as a result of the				
		the discomforts that each will cau	1 To			
	which are rare but may	be very serious, which are associa				
	risks have been explain					
<b>l</b> .	[사람들] (1. 그리고 1.	ITIONS WHICH MAY ARISE I un may arise, which were not anticipat				5. <b>*</b> 0.0
	necessary to correct wh	nay arise, which were not articipal attever problem develops. I therefo	re consent to the p	erformance of	such additional	procedures und
	these circumstances.					
5.		THESIA I consent to the use of				
	anesthesiologist. I give	permission for the use of whatever	type of anesthesis	a the anesthesi	ologist recomm	nends. I have bed
	explained to me.	sks and complications may result	firom anesthesia	and those his	es and complic	aliuns nave bee
<b>S</b> .		ON I hereby authorize and direct	the above named	physician and	or his associa	tes to provide th
	administration and mair	ntenance of conscious sedation. I h	nave been advised	of the benefits,	alternatives an	d risks associate
<u></u>	with conscious sedation			. I hove been	advised that the	ara is sama risk
7.	BLOOD TRANSFUSIO	NS Blood Transfusions may be re er reactions (No test exist which	quired. In this case can prevent ever	v possibility of	hepatitis or A	IDS.) I have bee
	advised that I can refus	The state of the s	can provent ever	, possione, o.		
3.	DISPOSAL OF ORGA	NS OR TISSUES The hospital	may examine an	d retain, for m	edical, scientif	ic, or education
- 14-55	purposes, any organs of	or tissues removed from the patie	nt. The hospital m	ay then dispos	e of them in a	ccordance with i
	usual practice.				oulta intended (	from the eneratio
9.	NO GUARANTEE No g	juarantees or assurances have be ician has discussed the likelihood	of achieving the e	ncerning the re xpected outcor	suits intended i ne.	nom me operano
		ve permission for such photograph				of the procedure(
ΙΟ.	as may be purposeful	for the advancement of medical	knowledge and/or	education, wit	h the understa	nding that my/th
	patient's identity will ren	nain anonymous.		•		
11.	FOR PATIENTS WHO	HAVE DNR ORDERS I understan	d and agree that the	e Do Not Resu	scitate Order w	rill be (check one Recovery, Room
		spended for the following peri	ou: (cneck one):	in the O	perating and	necovery noon
12	☐ Other (specify):	THIS FORM I have read and fully	understand this for	m. All blank spa	aces have been	completed. I have
	asked the physician any	questions I may have had. The pl	ysician has answe	red any questic	ons I asked to m	ny satisfaction.
DΔ	TIENT/DESCONT FOA	I Y AUTHORIZED TO CONSENT	TWITNE	SS		
(SIG	NA		(SIGNATU	HE) .		· —
(PRi	NT INTURE)		(PRINT NA	ME)		
(REL	ATIONSHIP, IF SIGNED BY PERSO	ON OTHER THAN THE PATIENT)	. (DATE)	10/0/02	(TIA	ME)
10 <b>1</b> 00 00000000000000000000000000000000		□ Language Line Name:	<u> </u>	10/1/00	·	
	<i>¥</i>	PHYSICIAN'	S CERTIFICATION	N		
her	by certify that I have ex	plained the nature, purpose, ben	efits, risks of, alte	rnatives to: cor	rscious sedatio	on, piood transius I haliava tha na
rop	osed procedure/operation	n; have offered to answer any que	iui 9vsn dns 2noii2 Sace benieined and	iy answered all Lanswered	Such questions	
Arce	on legally authorized to	consent fully understands what I h	iave expiairied and	a di lotto lou.		12/09/2
ÇI S					Date: _	1210712

EORM 00-0542 REV 8/05

WorkFlowOne Y0233709

	Wyckoff				3 1		•	·
	Wyckoff Holghts Medical Conter				M	RN:		
	CONSE	NT					Inpatient	M 37y
	PERMISSION FOR OPERA SPECIAL TREATMENTS	TION, ANEST OR PROCED	HESIA, URES				ADM	
	1. PERMISSION GRANTED Lara	ot say posmissis		$\Omega$	· <u>L</u> :	<del></del>	<u> </u>	
	655[][][][][][][][][][][][][][][][][][][			Descent of the	main		Or	his/her colleagues
	-10005100	1 1	nent	DE Pight	tient named a	bove the following	absoe.	•
	TYPE OR PRINT NAME OF PROCE  2. NATURE, PURPOSE, BENEFITS RECUPERATION HAVE BEEN E and advised me of any possible a  3. DISCUSSION OF THE RISKS A have been told what there risks	RISKS, COMPLET TO THE REPORT OF THE PROPERTY O	ICATIONS, L by the physic ing the risks a	IKELIHOOD OF ACH	IEVING THE (	GOALS and any F	OTENTIAL FOR	PROBLEMS IN T
•	have been told what these risks are rare, but very serious, and ar	and complication and complication in a special complication in the complex in the	TIONS includes are and the	discomforts that each	ions which ma	ay occur as a res	sult of the operat	operation/procedure.
	conditions may arise, which were problem(s) develop. I therefore of	hich may arise he not anticipated to the period to the per	ave been disc by my phys	cussed. I understand icians. If this happe	d that during tens, additiona	he course of the	operation or pro	me, as well. cedure, unforesec
5	for the use of whatever type of an anesthesia and those risks and c	consent to the usesthesia the ane omplications have	se of anesthe sthesiologist	sia to be applied by recommends. I have	and under the been advised	direction of the	anesthesiologist	. I give permissio
6	and maintenance of conscious/mo	TION: I hereby a derate sedation	thorize and c	lirect the above-name	ed physician a	nd/or his/her ass	nciatos to assist	
7.	other reactions. (No tests exist wirefuse blood transfusions.	transfusions m hich can prevent	ay be require every possib	d. In this case, I havility of hepatitis or HI	ve been advis V/AIDS transn	ed that there is s	some risk of hep	moderate sedation atitis, HIV/AIDS, o
8,	or tissues removed from the patie	R TISSUE: The	hospital may	examine and retain,	for medical, s	cientific, or educ	ational purpose.	··
	physician has discussed the likelih	es or assurance	s have been	made to me concer	ning the resul	ts intended from	this energian -	
10	PHOTOGRAPHY: I give permission be purposeful for the advancement and protected.  FOR PATIENTS WITH DATE CORRECTED	n for such photo t of medical know	graphing, videwledge and/d	ectaping, televising of reducation, with the	or other record understanding	ling/observation	of the operation/	procedure. The
ب <sup>1</sup> 11.	FOR PATIENTS WITH DNR ORDER	RS: I have thorou		d my wishes with the e following period:			e a legeritith Mill Le	main anonymous
. 12.	RECOVERY AND RECUPERATION Impact on the activities of daily living UNDERSTANDING OF THIS FORM	i	1		•			
13.	UNDERSTANDING OF THIS FORM	ig. A: I have read an	d fully unders	tand the cost-to-t	covery/recup	eration timefram	es and limitation	ns, including any
PEI	UNDERSTANDING OF THIS FORM the physician any questions that I make the physician and properties that I make the physician and properties the physician and physician	COMBENE.	4	• • • • • • • • • • • • • • • • • • • •		blank spaces hany satisfaction.	ve been complet	ed. I have asked
Sign		12/1/2	Z 9.1	WITNESS  I Com Signature	•		• • •	
<b>Sign</b>	atu	Date/Time / /	2 4.	Signature		<del></del> -	<u>·</u>	<u> </u>
. Print	Name	CONTRACTOR OF THE PARTY OF THE	2 7:1					
		Date/Time /		Print Name an	d Title	2 0941	\ .	<del></del>
	RPRETER USED  Not Applicable			Date and Time		- 0171	<u> </u>	
			(Identify by I	Vame or ID#)			•	
I here in the with author	eby certify that I have explained the recuperation. In addition, I have enthe alternatives. I have offered to an onjzed to consent for the patient. full	xplained the alte	rnative, include	R CERTIFICATION/ s, complications, like ling the option of no fully answered all si	elihood of act	.!	and any potential risks and benefit he patient/person	al for problems is associated
	elen ne sonder eldustris	: / ]	/	Date	red. : 12/1	/2022 Time:_	9:400	î i⊂yaliy Î.M
								• • •
Revie	ewed By:		7	•		•	•••	
Attend	ling/Operating Physician Signature	•		Date	: <u>.</u>	Time:		•

THIS DOCUMENT MUST BE MADE PART OF THE PATIENT'S MEDICAL RECORD.

Attending/Operating Physician Print/ID Stamp

0542 REV 4/14

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Wyckol	lleight	: Kledicel	Centor

#### \*CONSPROC\*

MRN

M **37y** Inpatient 11-29-22

Falestronit mitenditiereitenereinfiet en

**ADM** 

	BRIGH		
Permission	for oper	ATION, A	Nesthesia
APPRIAR TO			

CONCENT

Special treatments on procedures MINO . D:

•	PERMISSION GRANTED I BISIT MY DEMI	ssion to	D OCCO-		or his/her colleagues
•	associates or assistants at Wyckoff Heights	Medical Center, to pe	rform on the Patient named above the	foliowing:	
	bone binosy	RIGINA	400	· · · · · · · · · · · · · · · · · · ·	
		J	<del></del>	<del></del>	
	TYPE OR PRINT NAME OF PROCEDURE	•	• •	<del></del>	

- 2. NATURE, PURPOSE, BENEFITS, RISKS, COMPLICATIONS, LIKELIHOOD OF ACHIEVING THE GOALS and any POTENTIAL FOR PROBLEMS IN THE RECUPERATION HAVE BEEN EXPLAINED to me by the physician and why he/she is recommending it. He/she has also explained the expected outcomes and advised me of any possible alternatives, including the risks and benefits of those alternatives, including the alternative choice of no operation/procedure.
- 3. DISCUSSION OF THE RISKS AND COMPLICATIONS included those complications which may occur as a result of the operation or procedure, have been told what these risks and complications are and the discomforts that each could cause; I have also been made aware of certain risks which are rare, but very serious, and are associated with any surgical operation or procedure of this type. These have been explained to me, as well,
- 4. UNFORESEEN CONDITIONS which may arise have been discussed. Lunderstand that during the course of the operation or procedure, unforeseen conditions may arise, which were not anticipated by my physicians. If this happens, additional procedures may be necessary to correct whatever problem(s) develop. I therefore consent to the performance of any such additional procedures under these circumstances.
- 5: CONSENT TO ANESTHESIA: I consent to the use of anesthesia to be applied by and under the direction of the anesthesiologist. I give permission for the use of whatever type of anesthesia the anesthesiologist recommends. I have been advised that certain risks and complications may result from anesthesia and those risks and complications have been explained to me.
- 6. CONSCIOUS/MODERATE SEDATION: I hereby authorize and direct the above named physician and/or his/her associates to provide the administration and maintenance of conscious/moderate sedation. I have been advised of the benefits, alternatives and risks associated with conscious/moderate sedation.
- BLOOD TRANSFUSIONS: Blood transfusions may be required. In this case, I have been advised that there is some risk of hepatitis, HIV/AIDS, or other reactions. (No tests exist which can prevent every possibility of hepatitis or HIV/AIDS transmission.) I have been advised that I have the right to refuse blood transfusions.
- DISPOSAL OF ORGANS AND/OR TISSUE: The hospital may examine and retain, for medical, scientific, or educational purposes, any organs and/ or tissues removed from the patient. The hospital may then dispose of them in accordance with its usual practices.
- NO GUARANTEES: No guarantees or assurances have been made to me concerning the results Intended from this operation or procedure. The physician has discussed the likelihood of achieving the expected outcomes.
- 10. PHOTOGRAPHY: I give permission for such photographing; videotaping; televising or other recording/observation of the operation/procedure as may be purposeful for the advancement of medical knowledge and/or education, with the understanding that the patient's tdentity will remain anonymous and protected.
- 11. FOR PATIENTS WITH DNR ORDERS: I have thoroughly discussed my wishes with the physician(s). I understand and agree that the Do Not Resuscitate Other: (Specify)
- 12. RECOVERY AND RECUPERATION: The physician has discussed the expected recovery/recuperation timeframes and limitations, including any impact on the activities of daily living.
- 13. UNDERSTANDING OF THIS FORM: I have read and fully understand the contents of this form. All blank spaces have been completed. I have asked the physician any questions that I may have had. The physician has answered those questions to my satisfaction.

Sign-1-	THORIZED TO CONSENT  12/8 //;/3A/  Date/Time	Classics	
	12/8 . 11:13 AN	Signature	LN'
Print Name	Date/Time	- 13 - 08 - 33 · ·	11:13 m
Relationship, if signed by pe	erson other than the patient	Date and Time	
INTERPRETER USED		y Name or ID#)	•
I hereby certify that I have in the recuperation. In ac	e explained the nature, purpose; benefits; ri	DER CERTIFICATION/ATTESTATION  sks, complications, likelihood of achieving the go  uding the option of no operation/procedure and to	als and any potential for problems he risks and benefits associated

with the alternatives. I have offered to answer any questions and have fully answered all such questions. I believe that the patient/person legally authorized to consent for the patient, fully understands all that I have explained and answered,

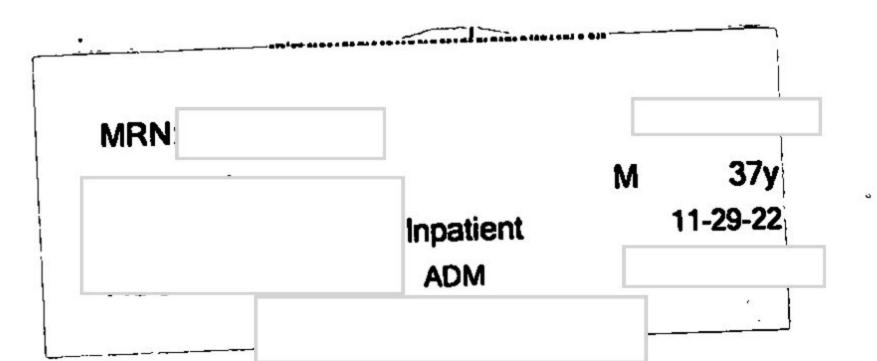
	 Date:_	148122.	_Time:	11:15 AN
Physician/Provider Signature	\$	5- <del></del>	1	
Physician's/Provider's Printed Name/ID Stamp Reviewed By:				
	 Date:		_Time:	
Attending/Operating Physician Signature	-			

Attending/Operating Physician Print/ID Stamp

0542 REV 4/14

THIS DOCUMENT MUST BE MADE PART OF THE PATIENT'S MEDICAL RECORD: ("PHYSICIAN" ALSO DENOTES DENTISTS, ORAL SURGEONS AND PODIATRISTS)





### Patient Property List

Clothing Disposition:	
Clothing sent home with (Name/Phone Number	r/Relationship):
ELECTRONIC DEVICES (Describe Items) Y/N:	
Cellular Phone:	
Tablet: _	
Laptop: .	
MP3 Player:	
Other Devices:	
Device Disposition:	
Valuables Envelope #	
Electronics sent home with (Name/Phone Num	ber/Relationship):
Medications Y/N: Medication Dispos	ition:
Medication sent home with (Name/Phone Number	er/Relationship):
Signature	Date: 11/30/2027
Witness	

The Hospital is not responsible for any clothing or property left

in the Hospital, or any money or jewelry left at the bedside.



## Patient Property List

Completed by Signature: Print Name:
Pt. educated about use of in room safe? (N/A ED and Peds.)
VALUABLES (Y/N): Checks: # to # Money: \$ 257. with pahent
IDs and Credit Cards: Jewelry (Describe Items):  metro plus health  metro cerd Ny hicense
Valuables Disposition: Valuables Envelope #  Samony Watch black
Valuables sent home with (Name/Phone Number/Relationship):
Dentures:
Dentures: Denture Disposition:
Dentures sent home with (Name/Phone Number/Relationship):
Comment: (If glasses or hearing aid, list here.)
CLOTHING (Describe Articles) Y/N:
shirt Oblack
Pants: black Sweath
1 10/12 Scmd10
Dress: - black Honey and blue sweats
Coat: N
Scarf: N
Gloves: N
Hat: Black
Other: Should bay Cblack
playergeme. [ minten 00 sutch)
D (D012



374 Stockholm Street, Brooklyn, New York 11237

NON - OR PROCEDURE VERIFICATION SHEET



FORM 00-0852 4/14 .

MRN:W850095359

5S 516-

Carrillo, Jose

1 37<sub>1</sub>

Depaz, Hector

ACC:W00851146725 ADM

Inpatient

11-29-2.

06-26-198

		L					<del></del>		<del></del>	<del></del>
Location/Clinic Fish floor	W	HM								
Procedure _		•		Da	ate _/	2/1	22	_ Time _	· .	
•		SIDE .			· - V.	0.47 \$1600. 10 10 10 10 10 10 10 10 10 10 10 10 10 1	in our sales	THE PARTY OF	# 2 Gr 7	7.7
PROCEDURE SUPPORT STAFF	LEFT	RIGHT	N/A	YES	NO-	310	April 1997	SIGNAT	URE	
1. Verify patient's full name.				1	J	8	.120			
2. Verify patient's date of birth.	<u> </u>	1		<u> </u>						<u>-</u>
3. Verify consent with patient as to		1								-
procedure/side/site. ~		. V								
4. Verify procedure/side/site with appropriate			[							,
medical record documentation.		~								
ANESTHESIA PERSONNEL PRESENT	LEFT.	RIGHT	N/A	YES	NO.		100	SIGNAT	URE	
Present:  Yes No		* C.A.	**************************************		(Associated Section 1)			Andrew Commence		
1. Verify planned procedure and site with		/								
patient.										
2. Verify consent as to procedure/site/side.		/			•					
PROVIDER PERFORMING PROCEDURE	LEFT	RIGHT	NA	YES	NO	AND A PROPERTY OF		SIGNAT	URE	3 4 3 4 C
Reconfirm procedure/side/site and consent with patient.		•		<b>/</b>						
2. If appropriate, mark site/side with indelible pen, mark to be visible after draping.										
<ol> <li>Verify presence of appropriate clinical studies, if applicable.</li> </ol>										
4. ASA status and MP classification verified .										
5. No sedation indicated	*** .			. 🗸	1					
VERIFICATION (TIME OUT)	LEFT	RIGHT	N/A	YES	NO	Terminal		SIGNAT	URE	
1. Availability of Needed Supplies/										
Equipment/Implants '										
2. Correct Patient Position										
CONFIRMED	LEFT	RIGHT	N/A	YES	NO		***	SIGNAT	URE	And the second
1. Provider Performing Procedure					,					•
2. Anesthesia Staff, if Present				1	,	•				
3. RN if Present	•			1	•					
4. Other Staff, if resent										•
DISPUTE RESOLUTION INITIATED .	• •	, , ;			1		_			•
DESIGNATED STAFF COMPLETING FORM:	Print Na	ame:								
	Title:		-	·		11	Date:		Time:	<del></del>
<b>5</b>	DE	M		•			12/	8/22		



374 Stockholm Street, Brooklyn, New York 11237.

			tal 6 & <sub>16</sub>	·	
ij.	MRN:W850095359		58	516-A	
	Carrillo, Jose		М	37y	
	Depaz, Hector	Inpatient	11-	-29-22	
	ACC:W0085114672	5 ADM	06-20	6-1985	
			HIII		

## NON - OR PROCEDURE VERIFICATION SHEET

Location/Clinic: 516A W	neko	ff Hi	Spifa	2/	Date:	12/1/2002 Time: 9240 am
Procedure: <u>incision</u> and	dole	brid	patr	ent,		Right foot of the pleases
PROCEDURE SUPPORT STAFF	LEFT	RIGHT	N/A	YES	NO	SIGNATURE & TITLE
1. Verify patient's full name		Ittorii	14/4	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	110	SIGNATURE & //
2. Verify Patient's date of birth	<del> </del>		<del> </del>		<del> </del>	<del></del>
3. Verify consent with patient as to procedure	<del>                                     </del>		<del> </del> -	1/	<del> </del> -	
side & site					ł	
4. Verify procedure side & site with						
appropriate medical record documentation						
5. Pre-procedure vital signs done and					1	
reviewed, intravenous access checked &	ĺ	1		\ \( \sigma \)		
functional  ANESTHESIA DEDCOMMEL DESCRIT	LECT	DICHT	1010	1	-	
ANESTHESIA PERSONNEL PRESENT  Present: Yes No	LEFT	RIGHT	N/A	YES	NO	SIGNATURE & TITLÉ
7		<u> </u>	<del>                                     </del>	<u> </u>		
1. Verify planned procedure & site with patient.						
2. Verify consent as to procedure / site / side	<del>                                     </del>			<del> </del>		
PROVIDER PERFORMING PROCEDURE	LEFT	RIGHT	N/A	YES	NO	SIGNATURE & TITLE
1. Reconfirm procedure side/site & consent			1	V	1	
2. If appropriate, mark site/side with indelible		3.0	1		1	<del> </del>
pen, mark to be visible after draping.				1		
3. Verify presence of appropriate clinical		1	1	-		
studies, if applicable				V	20.0	
4. ASA status and Mallampati classification			/		0.000	
verified			V			
5. Reviewed and evaluated patients History & physical including medications					1	
IMMEDIATE PRE-PROCEDURE	LEFT	RIGHT	N/A	YES	NO	CICNIATURE O TITLE /
VERIFICATION (TIME OUT)	LEFT	RIGHT	N/A	163	NO	SIGNATURE & TITLE
1. Availability of needed	-		<del> </del>		<u> </u>	
supplies/equipment/implants			1	///	ł	
2. Correct patient, position & site						<del>                                     </del>
3. Immediately, prior to induction/		<u> </u>		1		<del>                                      </del>
administration of sedation patient was				./		
reevaluated			<u> </u>			
CONFIRMED	LEFT	RIGHT	N/A	YES	NO	SIGNATURE & TITLE
1. Provider Performing						
2. Anesthesia Staff, if Present						
3. RN, if Present				V	WEST STATES	
4. Other Staff, if Present		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			•	
DISPUTE RESOLUTION INITIATED					**	
DESIGNATED STAFF PRINT NAME:	_	_	ı	٨	8	SIGNATUI
COMPLETING FORM:						
	IIILE:	101	1/1	DAIE:	101	1/22 - 9:40 an
		1/1/	V		-14	1100 - 1.40000
					•	E.



374 STOCKHOLM STREET BROOKLYN, NEW YORK 11237 MRN:W850095359

Carrillo, Jose

Depaz, Hector

ACC:W00851146725 ADM

5S 520-A

06-26-1985

Inpatient

37y 11-29-22

the state of the s

# PROGRĖSS NOTES .

**◀ START M.D. NOTEŞ HERE** DATE AND TIME Peripherally Inserted Central Catheter (PICC) Wave Form PICC-TIP 3CG CONFIRMATION (See Below). No x-ray required. VEIN UTILIZED: KAN Inserted by Erwin D. Tangonan, RN Catheter Measurements: EXTERNAL () () INTERNAL 21 MRN:W850095359 5S 520-A PowerPICC SOLO2™ Catheter with Sherlock 3CG™ Tip Positioning System (TPS) Stylet Carrillo, Jose 37y — (01)00801741155192 (17)230831 (10)REGQ1419 REF 1194108D5 Depaz, Hector Inpatient 11-29-22 LOT REGQ1419 ¥ 2023-08-31 ACC:W00851146725 ADM 06-26-1985 PIU1: Sherlock 3cg" Exit Site Marking: PID2: Tip Confirmation System 2022-12-12 13-06-37 **EXTERNAL INTRAVASCULAR** PICC tip location in the SVC confirmed by ECG technology



374 Stockholm Street, Brooklyn, New York 11237

## NON - OR PROCEDURE VERIFICATION SHEET



Location / Clinic \_ v

MRN:W850095359

Carrillo, Jose

Depaz, Hector

Inpatient

**37y** 11-29-22

5S 520-A

06-26-1985

ACC:W00851146725 ADM 

M

PowerPICC SOLO<sup>2™</sup> Catheter with Sherlock 3CG™ Tip Positioning System (TPS) Stylet IET 1194108D5 (01)00801741155192 (17)230831

된 2023-08-31

(01)00801741155192 (17)230831 (10)REGQ1419

Location / Clinic V/Willing Cov.					_		,	
Procedure Insertion of a Peripherally Insertion	rted Cen	tral Cath	eter (P	ICC) b	y Nu	rse Date WWW. Old	AM.	
the state of the s			,					
1. Verify patient's full name.								
2. Verify patient's date of birth.								
3. Verify consent with patient as to			5	/				
procedure/side/site.							╛	
4. Verify procedure/side/site with appropriat	е		}		<b>-</b>			
medical record documentation.		a/						
William Theory Francisco (Milliam Francis)		4/67	<b>V</b> <sub>f</sub> .	0 0 <u>0</u>	ł			
Present:   Yes  No	1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1							
1. Verify planned procedure and site with								
patient.	_	/				- <u></u>		
2. Verify consent as to procedure/site/side.			age.					
1 Poponium propoduro/oide/eite and	· .	144.	V 7.		ı	TOTAL TOTAL		
Reconfirm procedure/side/site and consent with patient.						Riffreguer		
<ol><li>If appropriate, mark site/side with indelible pen, mark to be visible after draping.</li></ol>	€				1	Richague	1	
<ol> <li>Verify presence of appropriate clinical studies, if applicable.</li> </ol>						Richaguer		
4. ASA status and MP classification verified			1				7	
5. No sedation indicated						Histogram		
15.45		*0%	77.1	71°5	11			
1. Availability of Needed Supplies/							7	
Equipment/Implants					<u>.                                    </u>	Higher	ĵ	
2. Correct Patient Position						Liferen	_	
1.1.1.1.121	1,	-1/51	dir	Mar:	۲.			
Provider Performing Procedure		/	<u></u>			Lifteguer	╛	
2. Anesthesia Staff, if Present	_						4	
3. RN if Present						Listeguer X D.	_	
4. Other Staff, if Present						•	_	
DISPUTE RESOLUTION INITIATED		•••					_	
DESIGNATED STAFF COMPLETING FORM	Print N			m		TO T 114 O PEO		
	Title:	Erwin D. Tangonan, RN #18579						
	Title.	Vascular Nurse Specialist  Date:  UNE Date:						
FORM 00-0852 8/12				100		SmartSourceLLC 01-150014	-A	