OR Setup

Primary responsibility: Nurse/Dental Assistant
Timing: Morning of the surgery (beginning of the day)
Location: OR/Surgical Suite/Operatory
Comments: Refers to one room (not patient); only performed 1x per day

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Resuscitation kit available and complete
☐ Yes ☐ Not Applicable

Filter for sterile water installed and functioning properly
☐ Yes ☐ Not Applicable

Enough surgical scrub brushes & antiseptic soap for all participants in surgery
☐ Yes ☐ Not Applicable

Vacuum functional
☐ Yes ☐ Not Applicable

Implant motor functional
☐ Yes ☐ Not Applicable

Surgical unit controlled
☐ Yes ☐ Not Applicable

Irrigation material and saline water available
☐ Yes ☐ Not Applicable

Surgical and implant kit(s) complete and sterilized
☐ Yes ☐ Not Applicable

Radiology equipment is functional
☐ Yes ☐ Not Applicable

Room Name: ______________________________

Date: ______________________________

Primary Responsible: ______________________________

Comments: ______________________________

This checklist shall not substitute appropriate medical verification prior to the intended procedure and shall be used as an additional informative tool only. FOR does not make any representation as to the accuracy, fitness or completeness of the checklist.