ACP PHLEBOLOGY SAFETY CHECKLIST
Assessment, Care, Plan

Patient Information
Please type or print clearly

First and Last Name: ________________________________________________

Date of Birth: _____________________________________________________ Medical Record: __________________________

Phlebology Safety Checklist

**Assessment**
- Essential imaging studies reviewed? ☐ Yes
- Procedure complexity reviewed? ☐ Yes
- CEAP:
- VCSS:
- Risk of DVT assessed? ☐ Yes
- Allergy history reviewed? ☐ Yes
- Patient optimized for the procedure? ☐ Yes

- Vital signs
- Personal health update
- Medication update
- Transportation / escort

**Care**
- Confirmation of patient identity and consent? ☐ Yes
- Confirmation of procedure, side and site? ☐ Yes
- EVTA
- Sclerotherapy
- Phlebectomy
- Other:
- Time out performed? ☐ Yes
- Required equipment available and in-date? ☐ Yes
- Emergency protocol reviewed? ☐ Yes
- Compression stocking available? ☐ Yes ☐ N/A

**Plan**
- Procedure results discussed with patient? ☐ Yes
- Assessment for pain? ☐ Yes
- Pain score:
- Unanticipated events recorded? ☐ Yes ☐ N/A
- Discharge criteria achieved? ☐ Yes
- Post-procedure instructions provided? ☐ Yes
- Follow-up plan discussed? ☐ Yes
- Post procedure documentation complete? ☐ Yes

Provider Information
Please type or print clearly

Name: ___________________________ Date: ___________________________

Signature: ___________________________ Time: ___________________________