American College of PHLEBOLOGY
advancing vein care

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: _____