Checklist – Day of Treatment
Intravitreal Injection

The ROYAL COLLEGE of OPHTHALMOLOGISTS

Patient ID

Name

D.O.B

Hospital No.

Date

Record allergies

CORRECT SITE AND CORRECT DRUG CHECKLIST
(Strike through if no treatment)

RIGHT EYE	LEFT EYES
Date Current Drug Commenced	Date Current Drug Commenced
Phakic ☐ Pseudophakic ☐ (please tick box)	Phakic ☐ Pseudophakic ☐ (please tick box)
☐	☐
☐	☐
☐	☐
☐	☐
☐	☐

Administer intravitreal treatment above as per clinical guidelines.
Eye(s) to be prepared using medication overleaf as per SOP for intravitreal injections:

Check 1: Verification of ID band, consent, correct site and drug checks by assessor.

Prescriber Signature

Reg Number

Print Name

Date / Time

Check 2: Verification of ID band, consent, correct site and drug checks by injection room treating doctor/nurse. To be read aloud during time-out before injection.

Signature

Print Name

Date / Time

Check 3: Verification of ID band, consent, correct site and drug checks by 2nd injection room support staff.

Signature

Print Name

Date / Time

Medication used before procedure (if indicated as per guidelines)	**Staff initial**

Medication used during procedure	**Staff initial**

Discharge Medication	**Staff initial**

Staff member to initial box above to side of medicines which they have administered and sign below

Signature		Print Name	
		Date / Time	
Signature		Print Name	
		Date / Time	
Signature		Print Name	
		Date / Time	