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 01/06/1900	Date Current Drug Commenced
Phakic ☐ Pseudophakic ✔ (please tick box)	Phakic ☐ Pseudophakic ☐ (please tick box)
Eylea 2mg ✔	Eylea 2mg
Ongavia 0.5mg	Ongavia 0.5mg
Vabysmo 6mg	Vabysmo 6mg
Beovu 6mg	Beovu 6mg

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

Trust Intravitreal Injection SOP Version x.x

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**
G. oxybuprocaine 0.4% minims / G. proxymetacaine 0.5% minims (delete as neces.)	
One drop of G apraclonidine 1% stat dose	

Medication used during procedure	**Staff initial**
G. oxybuprocaine 0.4% minims / G. proxymetacaine 0.5% minims (delete as neces.)	
G. povidone-iodine 5% minims	
Povidone-iodine 10% on skin	
G. sodium hyaluronate 0.4% preservative free stat dose	

Discharge Medication	**Staff initial**
Supply G. Hypromellose 0.3% prn to take home	

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	