

Operating Room Skills Checklist

Level of Proficiency:

- 1. Can function independently**
- 2. Experienced but may need review**
- 3. Limited or no experience**

By accurately filling out this checklist, you will help us match your skills and interest with available assignments. Please use an "S" for scrub, "C" for circulate or "B" for both. Place any of these letters under one of these numbers to best describe your expertise.

General Surgery	1	2	3	Orthopedic Surgery	1	2	3
Abdominal Perineal Resection	<input type="text"/>	<input type="text"/>	<input type="text"/>	Minor bone procedures	<input type="text"/>	<input type="text"/>	<input type="text"/>
Adrenalectomy	<input type="text"/>	<input type="text"/>	<input type="text"/>	Amputations	<input type="text"/>	<input type="text"/>	<input type="text"/>
Anal Fissurectomy	<input type="text"/>	<input type="text"/>	<input type="text"/>	Application of Halo Traction	<input type="text"/>	<input type="text"/>	<input type="text"/>
Appendectomy	<input type="text"/>	<input type="text"/>	<input type="text"/>	Various Fractures, Table Set-ups	<input type="text"/>	<input type="text"/>	<input type="text"/>
Cholecystectomy	<input type="text"/>	<input type="text"/>	<input type="text"/>	Body Cast	<input type="text"/>	<input type="text"/>	<input type="text"/>
Cholangiogram	<input type="text"/>	<input type="text"/>	<input type="text"/>	Hip Spike	<input type="text"/>	<input type="text"/>	<input type="text"/>
Circumcision	<input type="text"/>	<input type="text"/>	<input type="text"/>	Arthrotomy/Arthroscopies	<input type="text"/>	<input type="text"/>	<input type="text"/>
Colectomy	<input type="text"/>	<input type="text"/>	<input type="text"/>	Major Hip Nailing Procedures	<input type="text"/>	<input type="text"/>	<input type="text"/>
Colostomy	<input type="text"/>	<input type="text"/>	<input type="text"/>	Lumbar Instrumentation	<input type="text"/>	<input type="text"/>	<input type="text"/>
Ileostomy	<input type="text"/>	<input type="text"/>	<input type="text"/>	Shoulder Reconstruction	<input type="text"/>	<input type="text"/>	<input type="text"/>
Gastrectomy	<input type="text"/>	<input type="text"/>	<input type="text"/>	Spinal Fusion	<input type="text"/>	<input type="text"/>	<input type="text"/>

Hemorrhoidectomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tendon Transplants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatic Resection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Total Knee Replacement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Herniorrhaphy Femoral, Inguinal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Total Hip Replacement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hiatal Herniorrhaphy, Trans Abdominal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Herniarthroplasty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hydrocelectomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ophthalmology Surgery			
Imperforate Anus Reconstruction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Detached Retina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lumber Sympathectomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Corneal Transplant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pancreatectomy/Pancreateogram	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dacryocystectomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pilonidal Cystectomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dacryocystorhnostomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Portal Caval Shunt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Enucleation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Radical Mastectomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recession Resection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Saphenous Vein Ligation and Stripping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Repair Orbital Blowout Fracture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Splenectomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Phacoemulsifier Machine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroglossal Duct Cyst Excision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Video Camera	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroidectomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Microscope	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tracheostomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Plastic Surgery			
Vagotomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Septoplasty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

GYN Surgery

			Augmentation Mammoplasty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Caesarean Section	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Biopherosplasty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colposcopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cleft Lip/Palate Repair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D&C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mentoplasty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hysterectomy, Abdominal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Otoplasty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hysteroscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin Flap Grafts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Laparoscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reduction Mammography	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Laser C02	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rhinoplasty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Laser KTP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Scar Revisions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Laser YAG	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breast Reconstruction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Marsuprialization Bartholin Cyst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Oral/ENT Surgery			
Perineal/Vaginal/Urethra, Cervical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Closed Reduction Facial Fracture/Wiring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Condyloma w/Laser Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Teeth Extraction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Radium Insertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Endoscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salpinoplasty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Microlaryngoscopy W/C02 Laser	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shirodkar Operation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Microlaryngoscopy w/o C02 Laser	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suction Curettage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Caldwell-Luc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tubal Ligation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Commando Procedure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Vaginectomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ehtymordecotomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal Reconstruction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excision Salivary Gland Tumor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thoracic Surgery				Fenestration Procedure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest Tube Set-up Type	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Hiatal Hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pre/Post-OP & AORN Standards	Circulate		Scrub
Pneumonectomy/Lobectomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pre-op patient teaching	<input type="checkbox"/>		<input type="checkbox"/>
Sternal Splitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin Cleaning & Antisepsis	<input type="checkbox"/>		<input type="checkbox"/>
Thoracotomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wound Dressings	<input type="checkbox"/>		<input type="checkbox"/>
Bronchoscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Transfer of Patient -- To OR/Recovery	<input type="checkbox"/>		<input type="checkbox"/>
Lun/Wedge Resection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	OR Care Plans	<input type="checkbox"/>		<input type="checkbox"/>
Cardiovascular Surgery				Physician Preference Cards	<input type="checkbox"/>		<input type="checkbox"/>
A-V shunts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sterilization & Asepsis	<input type="checkbox"/>		<input type="checkbox"/>
Aortic Aneurysm, Abdominal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Positioning & Draping	<input type="checkbox"/>		<input type="checkbox"/>
Aorto-Femoral Bypass, Graft insertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Microbiology & Environment	<input type="checkbox"/>		<input type="checkbox"/>
Cardiac Valve Replacement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sanitation	<input type="checkbox"/>		<input type="checkbox"/>
Coronary Artery Bypass Graft	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Preparation of Supplies and Instruments	<input type="checkbox"/>		<input type="checkbox"/>
Endarterectomy-Carotid/Femoral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pre-op Shave	<input type="checkbox"/>		<input type="checkbox"/>
Femoral-Popiteal Bypass	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Review chart for Labs, Studies Consents, Allergies	<input type="checkbox"/>		<input type="checkbox"/>

External Temporary Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Use of Disposable Packs/Gowns	<input type="checkbox"/>	<input type="checkbox"/>
Internal Pacemaker insertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Proper Handling of Paper Wrappers	<input type="checkbox"/>	<input type="checkbox"/>
Intra-Aortic Balloon Pump Catheter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pre-op Holding area	<input type="checkbox"/>	<input type="checkbox"/>
Patent Ductus Repair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Pericardial Windows	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Porta-Systemic Shunt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Repair of Septal Defects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Thrombectomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Transplant Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Vena Cava Ligation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Recovery Room/ PACU	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

Name _____

Address _____

Date _____

Signature _____