**Central Line Insertion Procedure**

Date: <\_\_\_\_>

Time: <\_\_\_\_>

Indication: Hemodynamic monitoring/Intravenous access

Resident performing procedure: <\_\_\_\_>

Supervising Attending: <\_\_\_\_>

A time-out was completed verifying correct patient, procedure, site, positioning, and special equipment if applicable. The patient was placed in a dependent position appropriate for central line placement based on the vein to be cannulated. The patient’s <right/left> < neck/shoulder/groin> was prepped and draped in sterile fashion. 1% Lidocaine was used to anesthetize the surrounding skin area. A triple lumen <9-French Cordis> catheter was introduced into the <subclavian/internal jugular/common femoral vein> using the Seldinger technique under ultrasound guidance. The catheter was threaded smoothly over the guide wire and appropriate blood return was obtained. Each lumen of the catheter was evacuated of air and flushed with sterile saline. The catheter was then secured in place to the skin using a Stat-Lock and a sterile dressing was applied. Perfusion to the extremity distal to the point of catheter insertion was checked and found to be adequate.

<Attending/Resident> was present for the entire procedure.

Estimated Blood Loss: <\_\_\_\_>

The patient tolerated the procedure well and there were no complications.

Resident Name, PGY-#

Pager Number: