

Host Hospital Checklist for Sending and Receiving Provincial Ventilators

To be completed prior to ventilator shipping and upon return

NOTE: Host Hospital to contact the vendor(s) directly, for repairs, malfunctions or damages that fall within warranty terms and conditions.

Date: _____

Completed By: _____

Host Hospital Name: _____

Site Lead (Name and Title): _____

Contact Number and Email: _____

Please complete one form per ventilator (to be filed at your hospital)

Ventilator being (check one): Shipped Received For Rotation

Requesting Hospital Name		Requesting Hospital Contact Name and Number	
Type of Ventilator (AVEA, Evita XL, PB 840, Bella Vista, Servo-n)		Date Shipped / Received	
MOH Asset Tag Number	Hospital Tag Number	Serial Number	
Action	Status	Date	Initials
Read hours meter	Number of hours: _____		
Wipe down ventilator with hospital approved cleaning solution	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Biomedical electrical check (receiving only)	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Check overall condition of the housing	<input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Poor		
Keyboard/panel condition	<input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Poor		
Trolley/stand condition – casters	<input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Poor		
Scratches or damage on display field/screen	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____		
Power cord attached	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Patient circuit arm attached	<input type="checkbox"/> No <input type="checkbox"/> Yes		

Action	Status	Date	Initials
Inspiratory block and fittings checked	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Expiratory block and fittings checked	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Fan cover and filters in place	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Operator Manual (if requested)	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Vendor information on the ventilator	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Humidifier attached	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A		
Heated wire & temperature probe cables	<input type="checkbox"/> No <input type="checkbox"/> Yes		
O ₂ and air high pressure lines attached with DISS connections	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Circuits sent	<input type="checkbox"/> No <input type="checkbox"/> Yes: Number Sent ____		
Circuits returned	<input type="checkbox"/> No <input type="checkbox"/> Yes: Number Returned ____		
External flow sensor included	<input type="checkbox"/> No <input type="checkbox"/> Yes: Number Sent ____		
Heated Expiratory filter (Evita XL) sent	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A		
Expiratory filter 840 sent	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A		
Expiratory filter Avea sent	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A		

Standard Biomedical Test	Pass	Date	Signature
Performed by:	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Biomedical Engineering Electrical Safety Test	Pass	Date	Signature
Performed by:	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Respiratory Therapy Department Functionality Test	Pass	Date	Signature
Performed by:	<input type="checkbox"/> No <input type="checkbox"/> Yes		

This form was completed by:

Name:	
Position:	Contact Number:
Signature:	Date: