

# Requesting Hospital Checklist for Sending and Receiving Provincial Ventilators

To be completed upon receiving ventilator and prior to returning to Host Hospital

**NOTE:** Requesting Hospital to contact Host Hospital Site Lead immediately, for repairs, malfunctions or damages to ventilators.

Date: \_\_\_\_\_ Completed By: \_\_\_\_\_

Requesting 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

Host Hospital Name		Host 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	<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: _____		

Action	Status	Date	Initials
Power cord attached	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Patient circuit arm attached	<input type="checkbox"/> No <input type="checkbox"/> Yes		
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		
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 and temperature probe cables	<input type="checkbox"/> No <input type="checkbox"/> Yes		
O <sub>2</sub> 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/pots 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		
Vendor information on the ventilator	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Humidifier attached	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Heated wire and temperature probe cables	<input type="checkbox"/> No <input type="checkbox"/> Yes		

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:**

<b>Name:</b>	
<b>Position:</b>	<b>Contact Number:</b>
<b>Signature:</b>	<b>Date:</b>