# 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, V500, Carescape R860, Servo U, Servo-N, Hamilton T1)** | **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  | [ ]  **No** [ ]  **Yes** |  |  |
| Biomedical electrical check (receiving only) | [ ]  **No** [ ]  **Yes** |  |  |
| Check overall condition of the housing  | [ ]  **Very Good** [ ]  **Good** [ ]  **Poor**  |  |  |
| Keyboard/panel condition  | [ ]  **Very Good** [ ]  **Good** [ ]  **Poor**  |  |  |
| Trolley/stand condition – casters | [ ]  **Very Good** [ ]  **Good** [ ]  **Poor**  |  |  |
| Scratches or damage on display field/screen  | [ ]  **No** [ ]  **Yes: \_\_\_\_\_\_\_\_\_\_\_** |  |  |
| Power cord attached | [ ]  **No** [ ]  **Yes** |  |  |
| Patient circuit arm attached | [ ]  **No** [ ]  **Yes** |  |  |
| Inspiratory block and fittings checked  | [ ]  **No** [ ]  **Yes** |  |  |
| Expiratory block and fittings checked | [ ]  **No** [ ]  **Yes** |  |  |
| Fan cover and filters in place | [ ]  **No** [ ]  **Yes** |  |  |
| Operator Manual (if requested)  | [ ]  **No** [ ]  **Yes** |  |  |
| Vendor information on the ventilator | [ ]  **No** [ ]  **Yes** |  |  |
| Humidifier attached | [ ]  **No** [ ]  **Yes** [ ]  **N/A**  |  |  |
| Heated wire & temperature probe cables | [ ]  **No** [ ]  **Yes** |  |  |
| O2 and air high pressure lines attached with DISS connections | [ ]  **No** [ ]  **Yes** |  |  |
| Circuits sent  | [ ]  **No** [ ]  **Yes: Number Sent \_\_\_** |  |  |
| Circuits returned  | [ ]  **No** [ ]  **Yes:****Number Returned \_\_\_\_** |  |  |
| External flow sensor included  | [ ]  **No** [ ]  **Yes: Number Sent \_\_\_** |  |  |
| Heated Expiratory filter (if applicable) sent | [ ]  **No** [ ]  **Yes** [ ]  **N/A**  |  |  |
| Expiratory filter for specific ventilator sent | [ ]  **No** [ ]  **Yes** [ ]  **N/A**  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Standard Biomedical Test** | **Pass** | **Date** | **Signature** |
| Performed by: | [ ]  **No** [ ]  **Yes** |  |  |
| **Biomedical Engineering Electrical Safety Test** | **Pass** | **Date** | **Signature** |
| Performed by: | [ ]  **No** [ ]  **Yes** |  |  |
| **Respiratory Therapy Department Functionality Test** | **Pass** | **Date** | **Signature** |
| Performed by: | [ ]  **No** [ ]  **Yes** |  |  |

**This form was completed by:**

|  |
| --- |
| **Name:** |
| **Position:** | **Contact Number:** |
| **Signature:** | **Date:** |