

# Requesting Hospital Checklist for Sending and Receiving Provincial Airvos™ 2 Nasal High Flow Device

To be completed upon receiving Airvo™ 2 Nasal High Flow Device units and prior to returning to Host Hospital

*Please complete one form per Airvo™ 2 Nasal High Flow Device unit (to be filed at your hospital)*

Date: \_\_\_\_\_

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

Requesting Hospital Name: \_\_\_\_\_

Site Lead (Name and Title): \_\_\_\_\_

Contact Number and Email: \_\_\_\_\_

Airvo™ 2 unit being (check one):     Shipped     Received

Host Hospital Name		Host Hospital Contact Name and Number	
Type of Unit		Date Shipped / Received	
Airvo™ 2 Nasal High Flow Device			
MOH Asset Tag Number	Hospital Tag Number	Serial Number	

Action	Status	Date	Initials
Vendor information on the Airvo™ 2 unit	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Biomedical electrical check	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Passed the following tests:			
Heaterplate	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Check for leaks	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Check for blockages	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Check tube	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Power out	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Air filter present and filter cover attached	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Disinfection counter	Number: _____		
Wipe down with hospital approved cleaning solution	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Check overall condition of the Airvo	<input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Poor		

Action	Status	Date	Initials
Keyboard/Panel buttons 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		
Display condition (scratches/pitting/brightness)	<input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Poor		
Power cord attached	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Basket attached	<input type="checkbox"/> No <input type="checkbox"/> Yes		
High flow O2 meter and hose with DISS connection included	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Disinfection hose and filter attached	<input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Poor		
Air intake filter sent	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A Number:		
Air intake filter returned	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A Number:		
Circuits sent	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A Number:		
Circuits returned	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A Number:		
Comments for items marked as 'poor':			

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>