# 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, Bellavista, Carescape R860, Hamilton T1, PB 840, Servo-N, Servo-U, V500)** | | **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** |  |  |
| Disposable Expiratory Valve sent | **No  Yes Number sent: \_\_\_** |  |  |
| Reusable Expiratory Valve sent | **No  Yes Number sent: \_\_\_** |  |  |
| Reusable Expiratory Valve returned | **No  Yes Number sent: \_\_\_** |  |  |
| 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** |  |  |
| Heater wire cable | **No  Yes** |  |  |
| Temperature probe cable | **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 \_\_\_\_** |  |  |
| Test Tube (Circuits) for Servo N/U | **No  Yes  N/A** |  |  |
| End Tidal CO2 cable sent | **No  Yes** |  |  |
| End tidal CO2 cable returned | **No  Yes** |  |  |
| 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:** |