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 (Airvo 2, AVEA, Bella Vista, Carescape R860, Evita XL, 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	☐ **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**		

Updated: April 15, 2021

CCSO Critical Care Services Ontario

SMPCO Soins aux malades en phase critique Ontario

Action	Status	Date	Initials
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		
Vendor information on the ventilator	☐ No ☐ Yes		
Humidifier attached	☐ No ☐ Yes ☐ N/A		
Heated wire and temperature probe cables	☐ No ☐ Yes		
O_2 and air high pressure lines attached with DISS connections	☐ No ☐ Yes		
Circuits sent	☐ No ☐ Yes: Number Sent ____		
Circuits/pots 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 ventilator sent	☐ No ☐ Yes ☐ N/A		
Vendor information on the ventilator	☐ No ☐ Yes		
Humidifier attached	☐ No ☐ Yes		
Heated wire and temperature probe cables	☐ No ☐ Yes		

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:**