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**		

Action	Status	Date	Initials
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		
O_2 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:**