

Patient Name: _____ Patient DOB: _____ Breath Rate: _____
Tidal Volume: _____ PEEP/EPAP: _____ Sensitivity/Trigger: _____

☐ **Invasive Ventilator** Make/Model: _____ Serial Number: _____
PM Due: _____ Hours or _____ Date (Whichever occurs first)
Dual Prescription: ☐ No ☐ Yes _____
Mode: _____ I Time (Max/Min): _____ Pressure Support (Max/Min): _____
Pressure Control/IPAP: _____ Rise Time: _____ Backup Vent in Home: ☐ Yes ☐ No ☐ N/A

☐ **Non-Invasive Ventilator** Make/Model: _____ Serial Number: _____
PM Due: _____ Hours or _____ Date (Whichever occurs first)
Dual Prescription: ☐ No ☐ Yes _____ Leak: _____ LPM
Mode: _____ I Time (Max/Min): _____ Pressure Support (Max/Min): _____
VT (target): _____ PEEP/EPAP (Max/Min): _____ Rise Time: _____
Breath Rate: _____ VAPS Rate: _____
Pressure Control/IPAP: _____ Sensitivity/Trigger: _____

Oxygen and Humidification

☐ Oxygen Bleed In: _____ % FiO2 _____ LPM Duration: _____
Humidification in use: ☐ Heated, Type: _____ ☐ Cool ☐ HME ☐ None

Usage

Ventilator Usage: ☐ Continuous ☐ During sleep ☐ Other _____ hours/day Usage Hours: _____
Ventilator is connected in Cloud Platform: ☐ Yes ☐ No _____
Patient is using the ventilator > 4 hours in a 24-hour period: ☐ Yes ☐ No _____
Is patient compliant according to their plan of care: ☐ Yes ☐ No _____

Safety

Ventilator alarms appropriately set and functioning: ☐ Yes ☐ No _____
Internal and External batteries checked/charging/functioning ☐ Yes ☐ No _____
Emergency O2 in Place: ☐ Yes ☐ No _____
Manual Resuscitation Bag in Place: ☐ Yes ☐ No _____
Suction Machine clean and functioning: ☐ Yes ☐ No _____
Equipment Stored/Plugged in Safely: ☐ Yes ☐ No _____

Infection Control

Patient cleaning and changing supplies regularly ☐ Yes ☐ No _____
Patient receiving appropriate supplies timely ☐ Yes ☐ No _____
Last changed: Vent circuit _____ Bacterial filter _____ Vent Air Inlet filter _____

Plan of Care

Patient understands prescribed therapy ☐ Yes ☐ No _____
Patient is complying with their Plan of Care ☐ Yes ☐ No _____
Goals/Additional Comments: _____

Patient/Caregiver Signature: _____ Date: _____
RT Signature: _____ Date: _____