NIV Parental Education Checklist

Full Name: ....

Address: ....

HCR...

DOB: ___ / ___ / _____

Patient Details		
NIV: CPAP ☐		*BIPAP* ☐
Mask & Mask Size:		

Parental Education		
Established Patient's- Only requiring changeover of device	**Tick- once complete**	**Comments**
Device set up- turning on/off, batteries etc		
Humidification Set up		
Troubleshooting – (*auto start function should always be OFF*)		
Cleaning of the Device – incl *filters etc*		
Travel with Device		
Company follow up/yearly service/phone number given- (**if new provider**)		
NIV nurse follow up		

New Patients	**Tick – once complete**	**Comments**
Device set up- turning on/off, batteries etc		
Humidification Set up		
Troubleshooting – (***auto start function should always be OFF***)		
Cleaning of the Device – incl *filters etc*		
Application of Mask (snug not tight)		
Skincare		
Mask on Before Sleep / Sleep Hygiene		
Travel with Device		
Cleaning and Care of the mask		
Remote access		
NIV nurse follow up		
Respiratory team follow up		
Email address given		
Company follow up/yearly service/phone number given		

CNSp Signature & NMBI _____   **Parent Signature**_____