Patient/Caregiver Training Checklist

Patient Name: ____

Patient Address: ____

Trainers Name:____________________________________ Date:__________________________

Place of Training (circle one): Home Group Home Assisted Living Facility Other: ___________

Training Objectives

	Trainer Initials
1. Describe the intended use and rational for the BiWaze Cough System therapy	
2. Review safety instructions for the BiWaze Cough System	
3. Demonstrate the proper setup of BiWaze for therapy by assembling patient breathing circuit, connect to ACpower and switch on the device	
4. Describe the Auto therapy mode and features available for patient comfort (PAP on Pause, oscillations,inspiratory trigger)	
5. Review the therapy protocol the physician prescribed with the patient/caregiver	
6. Demonstrate how to run an Auto therapy and describe the information being displayed on the screen	
7. Review proper patient positioning for treatment	
8. Review the user manual with the patient/caregiver	
9. Review the order process for monthly patient breathing circuit replacement	
10. Demonstrate how to clean the device and patient breathing circuit	
11. Describe the maintenance needed and how to contact customer support	

Acknowledgement

The undersigned training and undersigned patient/caregiver each acknowledge that all the Training Objectives as marked above have been satisfactorily completed. The understand patient/caregiver further acknowledges receiving delivery of the BiWaze Cough Systemwith serial number_______________________.

Patient/Caregiver Signature:____Date:___________________

Relationship if other than the patient:____

Trainer Signature:____Date:___________________

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