BiWaze® Clear SYSTEM

Patient/Caregiver Training Checklist

Patient Name: _____

Patient Address: _____

Trainers Name: _____ Others Instructed: _____

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 Clear System therapy	
2. Review safety instructions for the BiWaze Clear System	
3. Demonstrate the proper setup by assembling patient breathing circuit, connect to A/C power and switch on the control unit	
4. Review the therapy protocol(s) the physician prescribed and how to select the profile(s)	
5. Demonstrate how to run an Auto therapy and describe the information being displayed on the touchscreen	
6. Review proper patient positioning for treatment	
7. Review the user manual with the patient/caregiver	
8. Review the order process for monthly patient breathing circuit replacement	
9. Demonstrate how to clean the control unit and Dual Lumen breathing circuit	
10. Describe the maintenance needed and how to contact customer service	

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 Clear Systemwith serial number _____.

Patient/Caregiver Signature: _____ Date: _____

Relationship if other than the patient: _____

Trainer Signature: _____ Date: _____

For further information about this product or a service, visit our webpage:
www.abmrc.com or call customer support: 1-877-ABMRC01 (877-226-7201)

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