Date:

	TIME														
	THÉRAPIST INITIALS														
SETTINGS	MODE														
	VT														
	FREQUENCY														
	FIO2														
	PEEP/PRESSURE SUPPORT														
	SENSITIVITY														
	INSP./PAUSE TIME														
	I E RATIO														
ABG	DRAW TIME														
	pH														
	PCO_2														
	PO_2														
	PULSE OXIMETER														
	T_cCO_2/END TIDAL CO_2														
OBSERVATIONS	SPONTANEOUS VT														
	SPONTANEOUS RATE														
	TOTAL VE														
	PEAK INS. PRESSURE														
	HEART RATE														
	SUCTIONED YES/NO														
	ANALYZED OXYGEN														
	BIL. BREATH SOUNDS														
ALARMS	HIGH PRESSURE														
	LOW PRESSURE														
	APNEA DELAY														
	LOW VT														
	LOW PEEP/CPAP														

Vent Type_____ Serial # _____ Date Set up_____ Date Intubated _____

Diagnosis _____

Attending Physician _____

Pulmonary Physician _____

Tube Size & Type _____

Ventilator Flow Sheet

University Hospital

Addressograph