EQUIPMENT USE INVENTORY

Directions: Answer the following questions related to equipment handling/transport in your department or that you may have access to through another department.

Department:			**Employee Name:**		**Shift: Day Night Swing**		
Resident Handling Device	Do you have this equipment in your dept? If Y - what's the name or brand?	If Yes, how many on unit?	What is the weight limit of the equipment if applicable?	How often do you use it? 4 = all the time 3 = most of the time 2 = sometimes 1 = rarely or never	Is this equipment in good working order? Y or N Comment	If used rarely or never, why?	Other Comments
1. Powered Floor Lift							
2. Ceiling Fan							
3. Powered Sit-to-Stand Lift							
4. Air Mat for lateral supine transfers, e.g. Hovermat							
5. Roller Mat							
6. Other types of Transfer mats or boards							
7. White Slide Board							
8. Slippery Sheets for repositioning							
9. Gait or transfer belt with or without handle							
10. Low- friction mattress covers							
11. Shower cart or gurney							
12. Shower or toilet chair							
13. Geri chair							
14. Wheel Chair							
15. Other chair types							
16. Adjustable height beds							
17. Other bed types							
18. Other							
19. Carts - Medicine							
20. Carts - Laundry							
21. Carts - Food							
22. Carts Other/Describe							
23. IV/Med Poles							
24. Other Medical Equipment							