

ISOLATION ROOM PRESSURE MONITOR CHECKLIST

ROOM NAME AND NUMBER _____

MONITOR MANUFACTURER AND MODEL NUMBER _____

This form should be completed **annually** and updated **monthly** for each room pressure monitor. Negative pressure should be verified **monthly** to validate the monitor. A copy of the completed form should be kept in the Policies and Procedure binder for the department.

MONITOR SETTINGS

Normal pressure reading (monitor reading with door closed) _____ " W.C.

Alarm will sound if pressure differential drops to _____ " W.C.

Time delay _____ seconds

Remote alarm location(s) _____

ANNUAL MONITOR CHECKS

TASK	DATE COMPLETED	SIGNED OFF BY
Monitor calibrated in accordance with manufacturer's requirements		
Confirmed negative pressure using smoke trail testing (this test should be repeated monthly and signed off below)		
Verified alarm operation (by holding door open or blocking off exhaust grille)		
Alarm sounded after _____ seconds		
Pressure reading at alarm _____ " W.C.		
Monitor use and functions demonstrated to all floor staff		

MONTHLY NEGATIVE PRESSURE CHECK

date/initials _____ date/initials _____ date/initials _____

date/initials _____ date/initials _____ date/initials _____

date/initials _____ date/initials _____ date/initials _____

date/initials _____ date/initials _____ date/initials _____