Product Evaluation Form
Splints/SecureSleeve

Facility Information

Facility Name: ______________________________________

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Department: ______________________________________

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Facility Contact Information

Name: ______________________________________

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Evaluation Information

Dates of Evaluation. Start: _______________End: _______________

Comparative Method (if any): ______________________________________

Purpose for using product / Condition of patient product being used on: ______________________________________

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Questions

For each element evaluated, rate the perception of this product. (Check box for yes or no.)

	YES	NO
The SecureSleeve was easy to apply around the patient's arm		
The SecureSleeve fit comfortably on the patient's arm		
The instructions and labeling on proper use and application were easy to understand		
The training and instruction on proper set up, application and use was clear and helpful		
The SecureSleeve adequately helped prevent the patient from accessing their tube/line		
The staff positively accepted the use and application of the SecureSleeve		
The training video and instructions were clear and properly demonstrated use and application		

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