Product Evaluation Form
SkinSleeves™ Protector

Facility Information

Facility Name: _____

_____

Department: _____

_____

Facility Contact Information

Name: _____

_____

Evaluation Information

Dates of Evaluation. Start: _____End: _____

Comparative Method (if any): _____

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

_____

Questions

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

	YES	NO
The SkinSleeves protector was easy to apply around the patient's arm	☐	☐
The SkinSleeves protector 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 SkinSleeves protector adequately helped prevent the patient from accessing their tube/line	☐	☐
The staff positively accepted the use and application of the SkinSleeves protector	☐	☐
The training video and instructions were clear and properly demonstrated use and application	☐	☐

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