Posey®

Product Evaluation Form
Self-Releasing Wrap-Around

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 Posey Self-Releasing Wrap-Around was easy to apply around the patient	☐	☐
The Posey Self-Releasing Wrap-Around fit comfortably on the patient	☐	☐
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 Posey Self-Releasing Wrap-Around provided the needed support for the patient while up in the chair	☐	☐
The staff positively accepted the use and application of the Posey Self-Releasing Wrap-Around	☐	☐

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