



SPECIALTY MEDICAL PRODUCTS, INC.

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PRODUCT EVALUATION FORM

START DATE: _____ END DATE: _____
FACILITY NAME: _____ Trial Leader _____
PRODUCT: _____ SMP Rep: _____

PLEASE RATE THE FOLLOWING:

(CIRCLE ONE)

EASE OF USE FOR CLINICIAN	POOR	GOOD	EXCELLENT
RESIDENT/PATIENT COMFORT	POOR	GOOD	EXCELLENT
PRODUCT DURABILITY	POOR	GOOD	EXCELLENT

CLINICAL EFFECTIVENESS:

PRESSURE REDUCING ABILITY	POOR	GOOD	EXCELLENT
SUPPORT & STABILITY FOR PT/RES	POOR	GOOD	EXCELLENT

WHAT ARE YOUR EXPECTED OUTCOMES FOR THIS PRODUCT?

_____	POOR	GOOD	EXCELLENT
_____	POOR	GOOD	EXCELLENT
_____	POOR	GOOD	EXCELLENT

DID THIS PRODUCT MEET YOUR EXPECTATIONS? **YES** **NO**

WOULD YOU LIKE TO SEE THIS PRODUCT USED IN YOUR FACILITY? **YES** **NO**

COMMENTS: _____

THANK YOU FOR YOU TIME AND INPUT

EVALUATOR'S SIGNATURE: _____ DATE: _____

APPROVE FOR RENTAL **YES** **NO**

APPROVE FOR PURCHASE **YES** **NO**

Please Fax to 610-644-3992
or
Email to info@smpcares.com