B&B Medical Technologies
Bite Proof Bite Block™ Product Evaluation

Hospital: _____ **Unit:** _____

RCP/RN: _____ **Date:** _____

Please rate the performance of the B&B Bite Proof Bite Block according to the following criteria:

5 = Exceptional **2 = Poor**
4 = Very Good **1 = Unacceptable**
3 = Good **0 = Not Able to Rate**

Return the Completed Evaluation form to your Product Evaluation Coordinator – Thank You

Oral Application		**Adult**	**Adolescent**

Performance Factors	**Rating**							**Comments**
	5	**4**	**3**	**2**	**1**	**0**	**Total**	
Ease of Use in Clinical Unit								
Complete Package								
Ease of Application								
Stability of Bite Proof Bite Block								
Patient Comfort								
Able to Provide Good Oral Care								
Overall Performance								
Total (add all ratings/divide by 7)								

Does the Bite Proof Bite Block meet your patient and clinical needs?
☐ Yes ☐ No Because _____

Does the Bite Proof Bite Block save time?
☐ Yes ☐ No Because _____

How many times did you apply the Bite Proof Bite Block during the evaluation? _____

Additional Comments