B&B Medical Technologies
TrachGuard™ Product Evaluation

Hospital: ____________________ **Unit:** ____________________

RCP/RN: ____________________ **Date:** ____________________

Please rate the performance of the B&B TrachGuard™ 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

Adult Application		**Pediatric Application**	

Performance Factors	**Rating**							**Comments**
	5	**4**	**3**	**2**	**1**	**0**	**Total**	
Ease of Use in Clinical Unit								
Complete Package								
Ease of Application								
Stability of TrachGuard								
Patient Comfort								
Prevent Disconnect								
Overall Performance								
Total (add all ratings/divide by 7)								

Does the TrachGuard meet your patient and clinical needs?
☐ Yes ☐ No Because ____________________

Does the TrachGuard save time?
☐ Yes ☐ No Because ____________________

How many times did you apply the TrachGuard during the evaluation? ____________

Additional Comments