

**CONFIDENTIAL**

Product Evaluation Form – Kliniderm Superabsorbent

Evaluation Start Date …….……. /…...….…. /…………….

Care Setting Primary Secondary Trust …………………………….................

Product evaluated …………………………………………….

Patient Initials ……………………………...............

Age ……………………………...............

Gender Male Female Current Product used …………………………….............

# Wound Type

Traumatic Wound Surgical Pressure Ulcer please circle EUPAP Stage 1 2 3 4 Diabetic Foot Ulcer Venous Leg Ulcer Arterial Leg Ulcer Mixed Aetiology

Other ……………………………………………………………….

# Wound Duration Exudate Level

0 – 4 weeks 5 – 12 13-24 over 24 None Light Moderate Heavy

**Treatment Aim**………………………………………………………………………………………………………………………………………………………………

Please complete the following table at each dressing change, rating the dressing’s performance **compared to the dressing you currently use** : 1= Very Poor, 2 = Poor, 3 = Average, 4= Good, 5= Excellent

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Date** | **Date** | **Date** | **Date** | **Date** | **Date** | **Date** | **Date** |
| **a) Patient comfort** |  |  |  |  |  |  |  |  |
| **b) Ease of product application** |  |  |  |  |  |  |  |  |
| **c) Ease of product removal** |  |  |  |  |  |  |  |  |
| **d) Conformability to wound** |  |  |  |  |  |  |  |  |
| **f) Ability to manage exudate** |  |  |  |  |  |  |  |  |

# Clinician Feedback

Evaluation End Date …….……. /…...….…. /…………….

How did the dressing perform compared

to **SORBION EXTRA**? Worse Equally Better

How did the dressing perform compared

To **Zetuvit PLUS** Worse Equally Better

Would you recommend this product for formulary inclusion Yes No

Any other comments? ……………………………………………………………………………………………………………………………………………………………..

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# Patient Feedback

Would you be happy to use the product again? Yes No

Any other comments?.....................................................................................................................................................................

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|  |  |  |  |
| --- | --- | --- | --- |
| Completed by | …………………………………………. | Position | …………………..…………………….. |
| Date | ……………/……………/………...... | Signed | ………………………..……………….. |
|  |  |  |  |

At H&R Healthcare Ltd we are committed to protecting and respecting your privacy. The personal information provided on this form will be used for the purpose of evaluating the performance of Kliniderm Superabsorbent. We will only keep your personal information for as long as required to complete the evaluation and in accordance with Good Clinical Practice Guidelines (GCP). Your personal data will be stored securely during this process. Please see [www.ich.org](http://www.ich.org/) for GCP Guidelines. H&R Healthcare Ltd’s company registration number is 05817827 and our registered address is: The Clock Tower Farleigh Court, Old Weston Road, Flax Bourton, Bristol, England, BS48 1UR.