

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
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Performance Factors	Rating							Comments
	5	4	3	2	1	0	Total	

Ease of Use in Clinical Unit								
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Complete Package								
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Ease of Application								
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Stability of Bite Proof Bite Block								
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Patient Comfort								
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Able to Provide Good Oral Care								
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Overall Performance								
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Total (add all ratings/divide by 7)								
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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