

**B&B Medical Technologies
Danny Ties™ Evaluation**

Size S _____ Size M _____ Size L _____

Hospital: _____

Unit: _____

RCP/RN: _____

Date: _____

Please rate the performance of the Danny Ties™ 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 the Product Evaluation Coordinator – Thank You

Patient Age		Patient Weight	
Trach Size			

Feature	Rating							Comments
	5	4	3	2	1	0	Total	

Ease of use in clinical area								
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Ease of set up & application								
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Stability of trach w/Danny Ties								
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Patient comfort w/padded collar								
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Absorbency of collar								
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Condition of skin before use								
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Condition of skin after use								
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Overall Performance								
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Does the Danny Ties meet your patient and clinical needs?

Yes No Because _____

Does the Danny Ties save time?

Yes No Because _____

How many times did you apply the Danny Ties during the evaluation? _____

Additional Comments