

LIMB-O™ CIRCUIT

To ensure the safety and performance of our products, AirLife™ would like your feedback on our Limb-O™ Circuit.

Please complete the evaluation form after using the product.

DATE _____

FACILITY / HOSPITAL _____

NAME + TITLE _____

DEPARTMENT _____



CIRCLE ONE FOR EACH STATEMENT YES NO IF NO, PLEASE EXPLAIN

Was the Limb-O single limb anesthesia circuit complete with all the necessary components? Yes No

Was having a circuit that is lighter weight a benefit? Yes No

Was the length of the circuit acceptable? Yes No

Was the circuit clinically acceptable? Yes No

ADDITIONAL COMMENTS:
