

# ANESTHESIA FACE MASK PRODUCT EVALUATION

DATE \_\_\_\_\_

FACILITY / HOSPITAL \_\_\_\_\_

NAME + TITLE \_\_\_\_\_

DEPARTMENT \_\_\_\_\_



LEVEL OF AGREEMENT (CIRCLE ONE FOR EACH STATEMENT)	1 VERY POOR	2 POOR	3 FAIR	4 GOOD	5 VERY GOOD
The device labeling is clear on size selection	1	2	3	4	5
The mask sizing fit the patient per my expectation	1	2	3	4	5
The mask provides an adequate seal and fit	1	2	3	4	5
The mask is clinically acceptable	1	2	3	4	5

**ADDITIONAL COMMENTS:**

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