

## ANESTHESIA FACE MASK PRODUCT EVALUATION

DATE \_\_\_\_\_

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

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

DEPARTMENT \_\_\_\_\_



### LEVEL OF AGREEMENT

(CIRCLE ONE FOR EACH STATEMENT)

Was the device labeling clear on size selection?	Yes	No
Did the mask sizing fit the patient per my expectation?	Yes	No
Did the mask provide an adequate seal and fit?	Yes	No
Is the mask clinically acceptable?	Yes	No

### ADDITIONAL COMMENTS:

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