Cutimed®

CUTIMED® OFF-LOADER SELECT EVALUATION FORM

Facility:_____

Patient number / Initials_____

Evaluator name (nurse or clinician):_____Title:_____Unit_____

Visit Date:_____

Criteria to be Evaluated:	Diagnosis/ CoMorbidity	Wound Location on Foot	Surrounding Skin Condition	Length of Time DFU Present	Any Prior TCC Use *specify name
Basic Data					

Criteria to be Evaluated:	Exudate Level	Viscosity
Low		
Medium		
High		

Criteria to be Evaluated:	Date 1st TCC was applied	Date Last TCC was applied	Total No. of weeks TCC was applied	Total No. of TCC applied
Basic Data				

Criteria to be Evaluated:	Poor	Fair	Good	Very Good	Excellent
Ease of Application					
Ease of Removal					
Patient Comfort					
Customizable to Difficult Anatomical Foot Conditions					

Overall Assessment - Comments:_____

I would recommend stocking this product in this facility: ❑ Yes ❑ No

Evaluation Period - Start Date:_____ End Date:_____

Wound Dressing Used:_____

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