Ray Mask Evaluation Form

Name: _____ Date: _____

Location: _____ Dept: _____

○ **Ray Nasal**

○ **Ray Full Face**

How would you rate this product?

	Meets Expectations	Exceeds Expectations
Ease of fitting mask	○	○
Product Design	○	○
Ease of using mask	○	○
Perceived patient comfort while using mask	○	○
Result Outcome	○	○

How often would you use this mask over another model?
Rate on a scale of 1-10 (1 being never, 10 being all the time)

1	2	3	4	5	6	7	8	9	10

Does this mask work as well or better than other pediatric masks? **Yes** **No**
Would you use this mask for your patients in the future? **Yes** **No**
Has the Ray mask saved time during fitting or reduced rework? **Yes** **No**
What are your suggestions on how to improve the mask?

_____

Additional thoughts or comments:

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