Ray Mask Evaluation Form

Name: _____ Date: _____

Location: _____ Dept: _____

○ **Ray Nasal**

○ **Ray Full Face**

A. Prior to Using Ray Mask:

What challenges did you face with other pediatric NIV masks?

_____

How did these challenges affect clinical workflow or patient outcomes?

_____

B. Trialing Ray:

What prompted you to try our Ray mask?

_____

Were there any concerns before trying it?

_____

C. Results:

How has the Ray mask improved clinical outcomes for your patients?

_____

Have any staff members provided specific positive feedback?

_____

D. Operational Benefits:

Any cost savings due to a decrease in mask changeover caused by fit problems?

_____

E. Anecdotal Evidence:

What would you tell another clinician or hospital considering trying Ray?

_____

Would you be willing to give a brief, 2-3 sentence testimonial about your experience using the Ray mask or working with Sunset Healthcare Solutions in general?

_____