Evaluation form

Clinician Name: …… Hospital/Dept: …….

Patient initials: …… Patient Age: …… Sex (circle): M or F

Wound/Ulcer History/challenge:…….

…….

Current wound bed preparation methods eg: wound cleanser/sharps debridement/surgical debridement (other please state) …….
Cost……. Secondary dressing? ……. Cost……

PRE- PLUROGEL - Wound/Ulcer Characteristics

How old is the wound (days)…….. Site:…….. Shape (circular, oval etc:)……

Size (cm)…….. Pain status:…… Level of exudate (circle): Low Med High

Visual assessment of tissue: (adherent, slough etc)……. Wound colour: …….

Necrotic tissue:…..% Granulating tissue …..% Sign of Infection Yes/No

Patient on antibiotics Yes/No (antibiotic name)…… Picture taken Yes/No

Plurogel Application:

Date of first application: …….. Frequency of application (days)……..

Duration of therapy (days)…….. Date of last application……

What secondary dressing did you use with Plurogel?……

POST PLUROGEL: Wound/Ulcer Characteristics

Shape (circular, oval etc:)…… Size (cm): …….. Pain status: ……

Level of exudate (circle): Low Med High Wound colour: …….

Visual assessment of tissue: (adherent, slough etc)……. Necrotic tissue:……%

Granulating tissue ……% Sign of Infection Yes/No (antibiotic name)……. Picture: Yes/No

Did Plurogel reduce the needs for sharps debridement **Yes** **No**

Has the Wound/Ulcer Improved (circle) **Yes** **No**

Rate of Healing	☐ Significantly Superior	☐ Superior	☐ Equivalent	☐ Inferior	☐ Significantly Inferior	☐ N/A
Reduction of wound debris/slough/necrotic tissue	☐ Significantly Superior	☐ Superior	☐ Equivalent	☐ Inferior	☐ Significantly Inferior	☐ N/A
Ease of application	☐ Significantly Superior	☐ Superior	☐ Equivalent	☐ Inferior	☐ Significantly Inferior	☐ N/A

Are there specific wounds you feel Plurogel will work on best? ……

……

What benefits will Plurogel bring for your patients? ……

……

What benefits will Plurogel bring to your department? ……

……

Will you introduce Plurogel for regular use within your department? Circle YES/NO

Please state Why?:……

……

Other comments ……

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Clinician signature…… Date: ……..