

Pepper Medical Evaluation Sheet: Trach Tie®

Name: _____

Facility: _____

Job Title: _____

Phone #: _____

Email: _____

Product #: _____

How often is product changed: _____

Does the product fit properly? If no, please specify where the product needs adjusting:

Did the patient experience any skin break down or irritation while using the product? Yes, No (circle one)

Did the edges of the neckband “roll” at all? Yes, No (circle one)

Additional Comments:

Thank you for taking the time to complete this evaluation sheet. We always appreciate our customers input.