Evaluation protocol – Foam mattresses

Health care facility: Date of evaluation period:

Ward + No:

Responsible: Phone: E-mail:

PRIMA ☐BM ☐6☐ 12
Optimal ☐M3 ☐M9 ☐BOB ☐Maxx ☐5zon ☐5zon BM ☐5zon Plus ☐Mono ☐Cura ☐Care ☐Solett ☐Solett BM

The patients age:_______ ☐Man ☐Woman Weight: Height:

Please use the modified Norton scale, Braden Scale or Waterlow Scale for risk assessment of the patient.

1. The patient's status/condition before evaluation Category: 1 – 2 – 3 – 4

Used risk assessment scale: ______________
Points:________

2. Indicate your assessment from 1-5 below. Please answer as many questions as possible.

The patient's review

Comfort?	☹ 1 – 2 – 3 – 4 – 5 ☺
To turn/move on the mattress?	☹ 1 – 2 – 3 – 4 – 5 ☺

Staff review

Working with the patient on the mattress?	☹ 1 – 2 – 3 – 4 – 5 ☺
To clean, embed and manage the mattress?	☹ 1 – 2 – 3 – 4 – 5 ☺
To understand attached instructions/user manuals?	☹ 1 – 2 – 3 – 4 – 5 ☺
How well has the mattress fulfilled your expectations?	☹ 1 – 2 – 3 – 4 – 5 ☺

3. Comments

____

____

____

____

Responsible signature: ____________________

© Care of Sweden AB, 2019-02-17

care of sweden
SUPPORTING LIFE