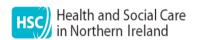




NI Wound Care Formulary Product Feedback Form	
Reporter Details	
Name and Professional Address:	
Postcode:	Tel. No:
Speciality/Job Title:	Tet. IVO.
Email Address:	
Signature:	
Product(s) Details (please indicate clearly the wound	management product that feedback is being
provided on by underlining or circling the name)	management product that recubuch is some
Primary Dressing Details	Secondary/Concurrent Dressing Details
Name:	Name:
Product Type:	Product Type:
Size:	Size:
Batch Number:	Batch Number:
Expiry Date:	Expiry Date:
Wound Details	
Wound Type, i.e. leg ulcer, pressure sore, etc:	Infected?:
	Antibiotics?:
Bed:	Any Other Relevant Information:
Exudate Levels	
Site:	
Size:	
Surrounding Skin:	
Odour:	
Pain:	
For DWMDC Hos Only	
For RWMPG Use Only:	
Date Received: Repeat Issue?	
Appropriate Dressing In Situ?	
Additional Information:	
Action Required:	





NI Wound Care Formulary Product Feedback Form		
Describe the specific problem that the patient has encountered with the dressing:		
Action Taken:		
Date of suspected problem:		
Risk Assessment:		
Do you consider the problem to be serious?		
If yes, please indicate why the problem is considered to be serious (please tick all that apply):		
Involved or prolonged in-patient hospitalisation		
Involved persistent or significant disability or incapacity		
Medically significant; please give details:		
medicany significani, piedse give delans.		
Patient Outcome		
Recovered		
Recovering		
Continuing		
Other; please give details:		
Please forward completed forms to:		
Fionnuala Lynch		
Lead Tissue Viability Nurse		
Hillsborough Health Centre		
29, Ballynahinch Street		
Hillsborough Co Down		
BT26 6AW		
Tel:07841102680 Email: fionnuala lynch@setrust hscni net		