

NI Wound Care Formulary Product Feedback Form

Reporter Details

Name and Professional Address:

Postcode:

Tel. No:

Speciality/Job Title:

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)

Primary Dressing Details

Name:

Product Type:

Size:

Batch Number:

Expiry Date:

Secondary/Concurrent Dressing Details

Name:

Product Type:

Size:

Batch Number:

Expiry Date:

Wound Details

Wound Type, i.e. leg ulcer, pressure sore, etc:

Bed:

Exudate Levels

Site:

Size:

Surrounding Skin:

Odour:

Pain:

Infected?:

Antibiotics?:

Any Other Relevant Information:

For RWMPG Use Only:

Date Received:

Repeat Issue?

Appropriate Dressing In Situ?

Additional Information:

Action Required:

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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:

Patient Outcome

Recovered

Recovering

Continuing

Other; please give details:

Please forward completed forms to:

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