



**THERMO CONTOUR ACUTE & LONGTERM CARE MATTRESS TRIAL FORM**

We would appreciate your help in evaluating our acute & longterm care mattress by answering the following questions:

Your name \_\_\_\_\_ Department \_\_\_\_\_

Hospital/ \_\_\_\_\_

Nursing Home \_\_\_\_\_ Telephone no \_\_\_\_\_

Patients risk status Norton/Waterlow Scale \_\_\_\_\_

Medical condition of patient \_\_\_\_\_

Weight \_\_\_\_\_ Male/Female \_\_\_\_\_ Age \_\_\_\_\_

Duration of trial \_\_\_\_\_ days

Did the patient find the mattress comfortable? Yes/No

Did you find the mattress convenient? Yes/No

What type of Pressure Relief product would you normally have used for the patient?

Nothing   
Inflatable Overlay   
Foam overlay

Low airloss overlay   
Sheepskin   
Low airloss bed

Other (specify) \_\_\_\_\_

Is the cover liked by you? Yes/No

by the patient? Yes/No

Is it easy to clean? Yes/No

Did the patient have pressures sores or marks on admission? Yes/No

If yes, where?

Sacrum Buttocks Heels Other (specify)

Yes/No Yes/No Yes/No \_\_\_\_\_

If yes, have the sores diminished / healed during the trial? \_\_\_\_\_

Did the patient develop any pressure sores or marks during the trial? Yes/No

If yes, where?

Sacrum Buttocks Other (specify)

Yes/No Yes/No \_\_\_\_\_

Any comments you would like to add: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date \_\_\_\_\_ Signed \_\_\_\_\_