THE O.R. COMPANY™
now part of
symmetry surgical®

Clinical Evaluation Form

Sales Rep:____________________________ Hospital:_________________________________

Date:________________________________ Specialty:________________________________

Circ. Nurse:__________________________

Procedure:____

PRODUCT (circle)

Uterine ElevatOR Pro with OccludeOR Balloon™ Uterine ElevatOR Pro™ ColpotomizOR Tube™

Suture PassOR Pro™ Port CLosOR Pro™ InsufflatOR Needle/Tubing

Liquid Scope HelpOR™ Liquid Scope WarmOR™ Scope HelpOR™ Scope CleanOR™

HolstOR PRO™ LapPakOR™ OTHER:___________________________

Performance: **(circle one)**

Clinical Performance:	**Very Good**	**Good**	**Acceptable**	**Unacceptable**
Ease of Use:	**Very Good**	**Good**	**Acceptable**	**Unacceptable**
Inclusion of Trocar Swabs	**Very Good**	**Good**	**Acceptable**	**Unacceptable**
Overall Performance	**Very Good**	**Good**	**Acceptable**	**Unacceptable**

Comments:____

____

____

Purchase recommended: Yes____ No____

Reasons: ____

PRINT NAME: _______________________

SIGNATURE: ________________________