Product / Equipment Assessment Form

MM31

Tracking #

Section 1 (Clinical Staff)

Name_____ Date____/____/____

Dept_____ Ext_____ Emergent Request ☐ Yes ☐ No

&RPSDQ\ Cost Center_____ Date Required____/____/____

Section 2 (Clinical Staff)

Product/Equipment Description_____ C-Code_____

Size _____ Catalog Number_____ Mfg_____

Price_____ Rep Name_____ Rep Phone Number_____

LP or Contract _____ If Contract, # _____ Consigned ☐ Yes ☐ No UOM_____

Section 3 (Clinical Staff)

Check All That Apply

☐ New Product ☐ New Technology ☐ Pt. Safety Issue ☐ SDS stock

☐ Replaces Existing Product ☐ Used w/ New capital equipment ☐ JCAHO Issue ☐ Non-stock item

If replacement product, list current hospital item number(s):

Does current product contain Latex? ☐ Yes ☐ No ☐ Unsure

Estimated Usage for All Depts:_____(in each quantities)

Latex_____ Latex Free_____

Is inservicing needed? ☐ Yes ☐ No

Is product FDA approved? ☐ Yes

(No, please note date sent to IRB) ☐ No Date / /

Does product require formal evaluation? ☐ Yes ☐ No

(If yes, please complete Section 9 (Side 2)

Clinical Acceptance Criteria

Section 4 (Clinical Staff)

(Please list Clinical Requirements)

Section 5 (Clinical Staff)

Is product used by other departments/divisions/sites?	☐ Yes	☐ No
Have other departments been notified about this request?	☐ Yes	☐ No

If yes, List Departments

Attach a copy of any approvals from other departments.

Signature Authority

Section 6 (Clinical Staff)

Department Head and/or _____ *Date* ____/____/____

Department Chair and/or _____ *Date* ____/____/____

Administrator/VP (if applicable) _____ *Date* ____/____/____

GL Code:_____

Please complete form in its entirety and FAX BOTH PAGES to the Contracting & Purchasing Department
484-884-1495

Product / Equipment Assessment Form

Clinical Evaluation Information

Section 7 (Clinical Staff)

Name of person coordinating Evaluation: _____

Location of evaluation: _____

Length of evaluation: ___/___/_____ to ___/___/_____

Clinical Evaluation Review

Section 8 (Clinical Staff or Committee performing final review)

Date of Review: ___/___/_____ Results of Review: Accept Reject

Reason: _____

Approved by: _____ Date: ___/___/_____

Title: _____ Committee: _____

Implementation Date: ___/___/_____

Financial Impact Calculator

Section 9 (Contracting & Purchasing Depa rtment)

Hospital ID #	Mfg	Description	Product Code	Annual Usage	Cost/UOM	Annual Cost

Proposed Product	Mfg	Description	Product Code	Annual Usage	Cost/UOM	Annual Cost

Annual Financial Impact: _____

Recommendations: _____

Signature: _____ *(Supply Chain Mgt)*

For questions regarding the completion of this form, please refer to the MM31 guidelines

Revised: 9/14/2017 by Nancy Zosky

Please save the completed form in your directory. (Click on File -> Save As -> PDF)