URICAP FEMALE DATA COLLECTION FORM

This form is used to collect data and observations from **Hospital** personnel who have applied the *UriCap Female*. Submit the completed form to your Device/Product Evaluation Coordinator or TillaCare Nurse. Thank you!

Part 1, 2, and 3 To be completed prior to device use and application.

1. FACILITY INFORMATION:

Date: _____/_____/_____

Unit/Department: ☐ _____ ☐ _____ ☐ Emergency Department ☐ ICU ☐ Other _____

UriCap Evaluator Name or Employee ID#: _____

UriCap Evaluator Credential: ☐ RN ☐ LPN ☐ C.N.A./PCT ☐ Other _____

Did you receive training on this device? ☐ Yes ☐ No

2. CLIENT INFORMATION: Prior to application

Client	**Initials:** _____	**Client Age or Birth Year:** _____	
BMI	**Height:** _____ inches **Weight:** _____ LB KG		
Selection Criteria	☐ Immobile/ Partially Immobile ☐ Incontinent ☐ No Allergy/Sensitivity to silicone ☐ Able to maintain rest for 1 hour after application	**Other Selection Criteira:** _____	☐ **Client is free of Contraindications***: Acute Urinary Retention, Pelvic Prolapse (≥ grade 2), Agitation/Pulling at Tube, Allergy/Sensitivity to silicone. **Do not appply with contraindications.*

Client Agreeemnt: ☐ Yes ☐ No If no, then stop with application. If no, provide details: _____

3. Application

Kit Selection	☐ Starter Kit ☐ Change Kit			
Perineal Assessment	☐ Perineal cleaning completed ☐ Clean, Dry, Intact	☐ Irritation ☐ Redness ☐ Wound	☐ Discharge ☐ Diarrhea	☐ Other _____ **Do not appply with localizez irritation, redness, wound*
Purpose of Application *select all that apply*	☐ Urine Output Monitoring ☐ Replace Indwelling Cather ☐ Urine Collection/Sampling ☐ Other_____		**This client previously utilized** *select all that apply*: ☐ Indwelling or Straight Cather ☐ Briefs/Pads ☐ External Catheter ☐ Other_____	
Application Attempts	☐ 1 – 3 Attempts ☐ 5 – 5 Attempts	☐ ≥ 6 Attempts ☐ Unable to apply	If ≥ 6 Attempts or unable to apply, what do you feel contributed to this _____	

Was the client able to maintain resting position for one-hour: ☐ Yes ☐ No If not, explain: _____

During the first 2 hours of UriCap use, was the client incontinent? ☐ Yes ☐ No If not, explain: _____

Client Response *after* one hour of use: _____

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4. *URICAP FEMALE* DURING USE

CLIENT INFORMATION

Removal Date ____/____/_____ **Removal Time** ____:_____ AM PM **Hours of UriCap Use:** _____

Total Collected Urine (ml) in Bag: _____ ml

Removal occurred: ☐ Scheduled ☐ Client Self-removed ☐ Accidental removal or Dislodgement ☐ Mobility related nonadherence

Health Effects	☐ Leakage ☐ Redness	☐ Irritation ☐ Wound	☐ Other _____

STAFF/NURSING TRAAINING

Which UriCap Training did you complete? *Check all that apply* ☐ TillaCare RN ☐ Hospital Staff/Nursing ☐ Online Course

Was the training adequate? ☐ Yes ☐ No If no, explain: _____

Rate the quality of training materials/video: ☐ Excellent ☐ Above Average ☐ Average ☐ Fair ☐ Needs Improvement

Rate the Ease of Application: ☐ Effortless (1st attempt) ☐ Easy (1-5 attempts) ☐ Possible with practice (1 - 5 attempts, trainer assisted) ☐ Difficult **(**Unable to apply after 5 attempts)

5. PERFORMACE OF URICAP

Rate the URICAP FEMALE for each the following using the scale of *Strongly Agree* to *Strongly Disagree*

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
The intended purpose(s) of the device was clear					
The device parts were easy to assemble (*UriCap, tube, bag*)					
The device was easy to secure to the client					
It was easy to view and monitor urine output					
The device contributed to maintaining clean, dry, intact skin					
The device was easy to remove/discontinue					
The device is a potential replacement for absorbent products (pads, briefs)					
The device is an environmentally preferable product over pads/briefs					
The device is a suitable replacement for indwelling catheterization in this client set					
The device has the potential to reduce total number of catheter days					
The device meets clinical needs for safe, urine collection and monitoring					

Submit the completed form to your Device/Product Evaluation Coordinator. Thank you!