The Silicone Centre
Creating life like silicone

Check Socket Feedback Form

Patient Name/Ref: _____

Company Name: _____
Practitioner: _____
Contact No: _____
Email: _____

Item Code/Description:
_____

	Good	Comments
Fit	☐	_____
Length of Digits	☐	_____
Size of Digits	☐	_____
Alignment	☐	_____
Thickness of Silicone	☐	_____

Other / Additional Comments:

_____
_____
_____
_____
_____
_____
_____
_____

Date: _____