TickleFLEX®
INSULIN INJECTION AID

TickleFLEX Evaluation Form

Name:	
Title:	
Organisation:	

1. Do you feel that TickleFLEX will be useful for diabetics who have difficulty with injecting due to pain and/or needle phobia?

   Yes ☐ **No ☐**

2. Do you feel that TickleFLEX will help children to overcome the worry of injecting and therefore self-inject with less anxiety and more confidence?

   Yes ☐ **No ☐**

3. Do you feel that TickleFLEX will be helpful to newly diagnosed diabetics who need to inject?

   Yes ☐ **No ☐**

4. Due to the reduced pain associated with using TickleFLEX, do you feel it will encourage people to use more sites around the body to inject?

   Yes ☐ **No ☐**

5. Do you feel that TickleFLEX should be available on NHS prescription?

   Yes ☐ **No ☐**

6. How was TickleFLEX received by patients / colleagues who you have presented it to?

7. Do you think TickleFLEX will make your job easier with people who have issues injecting?

Yes ☐ **No ☐**

8. Do you feel that the packaging clearly describes the purpose of TickleFLEX? If not, what would you suggest needs to be changed?

Yes ☐ **No ☐**

9. Do you have any suggestions for product improvement?

10. Please summarise your overall evaluation:

Thank you for taking the time to complete this evaluation, we very much appreciate it.