Physician Order for Catheterization

Name of Student:____ Birth Date:__________________

1. The above student is being treated for:____

____

2. Name of procedure: **Catherization**

   The parent is required to provide the necessary supplies.

3. Procedure Information:

   Catheter size___________________________ Latex____________________

   Frequency_____________________________ Plastic___________________

	(circle one)	
Independent self-cath	Yes	No
Assisted self-cath	Yes	No
Crede Procedure	Yes	No
Diapering required	Yes	No

   Solution used for cleaning____

   Special instructions____

   ____

4. This procedure is to be continued as above until:__________.
   Date

All authorizations expire at the end of the current school year.

5. This procedure MUST be performed by licensed personnel only. Yes___ No____
   Be advised that RN's are not in the building every day and some of the procedures are done by trained unlicensed personnel.
   Please specify a person from your facility who can provide training for school personnel.

Name:____ Phone:______________________

Note: RN may need to contact physician in writing or by phone.

Physician's Signature:_____________________________________ Date:________________________

Print Physician's Name:___________________________________ Phone:______________________

Parent permission: I hereby request that the treatment specified above be performed to the above-name child.

___________________________________ ______________________ ______________

Signature of Parent/Guardian Phone Date