Physician Order for Catherization

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.

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