Clean Intermittent Urinary Catheterization Care Plan and Order for Prescribed Services

Student Name:_____ DOB:_____
School:_____ Grade:_____ Date:_____

To Be Completed By Healthcare Provider:

Students Medical Diagnosis:_____

Catheterization: ☐ Urethral ☐ Suprapubic

Student can perform catheterization independently:

☐ Yes ☐ Yes, with supervision ☐ No

Students urine is typically: ☐ Clear ☐ Cloudy ☐ Odiferous ☐ Blood tinged

Typical Urine Color:_____

Timing for catheterization:_____

Student Position During catheterization:_____

Notify parents if:_____

Other recommendations:_____

Date to be discontinued:_____

I am aware that the parent/guardian will train the staff/unlicensed assistive personnel to perform the Clean Intermittent Catheterization.

*Standards of care available upon request

Licensed Provider Name:_____ Phone No:_____

Licensed Healthcare Provider Signature:_____ Date:_____

I agree with the above care plan and to provide necessary equipment/supplies properly labeled for use in school. I will train the staff/ unlicensed assistive personnel to administer the above procedure. If the procedure changes, written verification from your licensed health care provider is required. I grant permission for the school staff to communicate directly with the above-named provider, regarding any questions or concerns regarding this procedure. I will notify the school of changes in procedure or provider.

Parent/Guardian Signature:_____ Phone No._____ Date:_____