



## **CLEAN INTERMITTENT CATHETERIZATION**

Student's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Diagnosis \_\_\_\_\_

ICD-10 Code \_\_\_\_\_

How often \_\_\_\_\_

What time (s) \_\_\_\_\_

Catheter Size and type \_\_\_\_\_

Cleanse with what \_\_\_\_\_

Measure ☐ Yes ☐ No

Self Cath ☐ Yes ☐ No

Cath by Staff ☐ Yes ☐ No

\_\_\_\_\_  
Physician's Printed Name

\_\_\_\_\_  
Physician's NPI Number

\_\_\_\_\_  
Physician's Address

\_\_\_\_\_  
Phone/Fax Number

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date