NSW GOVERNMENT Health
Western Sydney
Local Health District

Facility:

AUTHORITY FOR INDWELLING URINARY CATHETER

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. ___/___/___	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

☐ I hereby authorise the Community Health Nurse to attend the ongoing indwelling urinary catheter changes for the client as stated above.

☐ I hereby authorise the Community Health Nurse to insert an indwelling urinary catheter for the client as stated above and to attend to ongoing catheter care as required.

Indication for indwelling urinary catheter	
Type of catheter	☐ Supra pubic ☐ Urethral
Spinal Cord injury	☐ Yes ☐ No
History of Autonomic Dysreflexia	☐ Yes ☐ No

Medical Officer

Name _____ Phone: _____

Fax: _____

Signature _____ Email: _____

Please return to

Name _____ Fax: _____

Email: _____

Name (print): _____ Signature: _____

Designation: _____ Date: ___/___/___

NO WRITING