Phone: 1300 723 224
Fax: 1300 734 224
Email:
intake@remedyhealthcare.com.au

Medical letter of Authority- Catheter management

Client Name: _____ DOB: __ / __ / ____

Client Address:

_____

_____

Telephone: (H) _____ (M) _____ (Other) _____

ALERTS and ALLERGIES (please indicate or N/A):

Please advise of all know allergies (including product related allergies)	
Does the client have recurrent urinary infections?	
Has the client had a previous difficult catheter insertion/removal?	
Is the client receiving anticoagulation/antiplatelet therapy?	
Other issues:	

Current Catheter insitu:

Date inserted: ___/___/_____

Type_____ Size (gauge):_____

I hereby authorize the nurse clinician to attend to my client's catheter insertion/change as indicated below:

Catheter Type (please circle)

Male/Female Suprapubic Catheter Urethral Catheter

Gauge (please circle) 14 16 18 20 22

Intermittent Catheter: Length required (cm)_____
Lubricant required_____

Describe requested care:

_____

_____

_____

_____

Doctors Name _____

Doctors Signature_____

Provider number_____

Date:___/___/20___

Medical letter of Authority – Catheter Management