Houston Independent School District
Health and Medical Services

Physician Orders for Urinary Catheterization

To the Nurse of: _____School Student ID Number: _____
Child's Name: _____ Date of Birth: _____

Diagnosis: _____ Allergies: ☐ Latex ☐Other _____

Etiology _____ Prognosis _____ Date of Onset _____

Procedures(s) required for the student while in the school setting (check and complete all sections that apply):
☐Clean Intermittent Catheterization ☐Sterile Catheterization
☐Male ☐Female

Catheterization Orders: (check and complete all sections that apply):
☐Every _____hours
☐Specific Times as listed: _____ _____ _____ _____
☐PRN
☐Parent may adjust the catheterization schedule
☐Intermittent Catheterization by School Nurse
☐Intermittent Catheterization by the Student (Self-Cath)
☐Assistance or Monitoring Needed with Self-Cath
☐Catheter Size: _____
☐Crede

Possible Problems include:

Problem:	Reason:	Action:
1. Bleeding from the urethra	Trauma to the urethra	Discontinue catheterization. Contact family, recommend contacting physician.
2. Inability to pass catheter	Increased sphincter tone caused by anxiety or spasm.	Encourage relaxation (i.e. deep breathing) In boys: Reposition the penis and use gentle but firm pressure until the sphincter relaxes. Flex at hips to decrease reflex resistance of bladder sphincter. In girls: Check catheter placement. If the catheter is in the vagina do not reinsert, rather use a new catheter. If unsuccessful notify family, recommend contacting the physician.
3. No urine as a result of catheterization	May be due to improper placement of catheter or the bladder may be empty.	Check position of catheter.
4. Cloudy urine, mucus, blood, foul odor, color changes, or unusual wetting between catheterizations	May be due to a urinary tract infection.	Report to family any changes in the student's usual pattern or tolerance of procedure.

Circumstance in which the physician is to be contacted: _____

_____

Special instructions: (Include precautions, possible reactions and interventions) A registered nurse will coordinate the health care of all students, including medications, treatments, and prescribed procedures.

_____ _____ _____
SIGNATURE OF PHYSICIAN **TELEPHONE** **DATE**

I request the above procedure(s) be administered to my child as ordered by the physician. I authorize the school nurse to contact my child's physician for information concerning my child when necessary.

_____ _____ _____
SIGNATURE OF PARENT **TELEPHONE** **DATE**