Lexington County School District One

Intermittent Catheterization Physician Orders

School Year:_____

Student Name	DOB	Grade	School

Diagnosis:	ICD-10 Code:

Type/Location of ostomy (if present):	Catheter Size:

Frequency of I/O catheterization:	Measure and record output? Yes □ No □

Additional instructions for ostomy care: _____

_____

_____

Instructions for when to contact physician:

_____

_____

_____

By signing this form, the parent/guardian and health care practitioner acknowledge that information provided on this form may be included in the student's Individual Healthcare Plan.

Health Care Provider Name _____**Date**_____

Health Care Provider Signature_____

Phone_____**Office Nurse's Name/ other contact for questions** _____

Parent/Guardian Name_____**Date**_____

Parent/Guardian Signature_____

Phone (home)_____ **(work)** _____ **(cell)**_____