Date: __________

This patient has had an indwelling urethral catheter since __________.

Please indicate below either your 1) approval to remove the catheter OR 2) state the reason for continued indwelling urethral catheterization.

☐ Please discontinue indwelling urethral catheter; OR
☐ Please continue indwelling urethral catheter because patient requires indwelling catheterization for the following reasons (please check all that apply):
  □ Patient has acute urinary retention or bladder outlet obstruction
  □ Need for accurate measurements of urinary output in critically ill patients wound
  □ To assist in healing of open sacral or perineal wounds in incontinent patients
  □ Patient requires prolonged immobilization (e.g., potentially unstable thoracic or lumbar spine, multiple traumatic injuries such as pelvic fractures)
  □ To improve comfort for end of life care if needed
  □ Other - please specify: ________________________________

______________________________  ________________________________
Physician's Signature            Doctor Number
Date: __________

This patient has had an indwelling urethral catheter since __________.

Please indicate below either your 1) approval to remove the catheter OR 2) state the reason for continued indwelling urethral catheterization.

☐ Please discontinue indwelling urethral catheter; OR

☐ Please continue indwelling urethral catheter because patient requires indwelling catheterization for the following reasons (please check all that apply):

  ☐ Urinary retention
  ☐ Very close monitoring of urine output and patient unable to use urinal or bedpan
  ☐ Open wound in sacral or perineal area and patient has urinary incontinence
  ☐ Patient too ill or fatigued to use any other type of urinary collection strategy
  ☐ Patient had recent surgery or radiation to the pelvic area
  ☐ Management of urinary incontinence on patient’s request (documented in chart)
  ☐ Other - please specify: _______________________________________________________

________________________________________________________________________

___________________________  __________________________
Physician’s Signature        Doctor Number