



CATHETER DIARY

Name:

Health-care Professional
(District Nurse / Practice Nurse Etc.):

Phone Number:

Clinic Number:

Working Hours:

Out of Hours Number:

G.P. Number:

CATHETER DIARY

Please ensure this booklet is completed each time your catheter is changed

Name:

Address:

G.P.:

Consultant:

Hospital Number:

1a. Reason for catheterisation:

1b. Date of initial catheterisation:

2. Recommended catheter:

Manufacturer:

Catheter
change date:

Insertion easy
 yes no

Comments/problems:

Reason for change: Routine Fallen Out Baloon Burst Blocked

Catheter maintenance solutions/antibiotic therapy details:

CSU: Yes
No

Name of nurse/doctor/carer:

Date of next catheter change:

Catheter
change date:

Insertion easy
 yes no

Comments/problems:

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Date of next catheter change:

WITH THANKS TO:

Judy Dakin

Continence Advisor
Waltham Forest PCT

Dee Blaikie

Continence Advisor
Whipps Cross
Hospital

Carol Impey

Continence Advisor
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