NSW GOVERNMENT Health
South Western Sydney Local Health District

COMMUNITY HEALTH SERVICES

AUTHORITY TO PERFORM CLINICAL PROCEDURE BY NURSE

SURNAME	MRN
OTHER NAMES	☐ MALE ☐ FEMALE
D.O.B. _____/_____/_____	M.O.
ADDRESS	
LOCATION	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

URINARY CATHETERISATION

☐ Suprapubic ☐ Urethral Date of last insertion: _____

Catheter Size: _____Fg Balloon Size: _____ml Catheter Material (eg. Silicone): _____

Is the patient at risk of autonomic dysreflexia? ☐ Yes ☐ No

Have there been any complications during or following catheterisation? ☐ Yes ☐ No

Details: _____

_____

Frequency of catheter change: Every _____weeks

Specific catheter type/drainage equipment required: _____

_____

SUTURES & SURGICAL CLIPS

Site of suture/clip	Date to be removed

Name of Surgeon:_____ Telephone: _____

PRINT

DRAIN MANAGEMENT

Drain site	Drainage device	Removal date	Removal & care instructions

Name of Surgeon: _____ Telephone: _____

PRINT

OTHER CLINICAL THERAPY REQUIRING AUTHORISATION

_____

_____

AUTHORISING CLINICIAN (Medical Officer/General Practitioner)

Name:_____ Signature_____

Designation: _____ Date: _____ Telephone: _____

THIS AUTHORITY REQUIRES RENEWAL EVERY 12 MONTHS

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AMR 024.000

BINDING MARGIN – NO WRITING

FILE IN CLINICAL RECORD

ID 6070887 Oct 13