



REFERRAL FOR URINARY CATHETER ISSUES

Residential Care Line

Date of referral: ____/____/____	Facility	Facility number:	
Resident name:		DOB:	
GP Name:		GP aware of referral: ☐ YES ☐ NO	
GP Number:			
AHD / ACP / GoC: ☐ YES ☐ NO		Date completed:	
CNM name:			
CNM aware of referral: ☐ YES ☐ NO			
Name of referrer:			
Description of Issue (Click relevant)			
☐ Blocking	☐ Bypassing	☐ Haematuria	
Type of Catheter (Click) ☐ IDC ☐ SPC			
Catheter Type & Size (FR)			
Date of last change: ____/____/____		Frequency of changes	
TOV Hx		Permanent catheter ☐ YES ☐ NO (Click)	
Securing device in use for: Catheter:		Bag:	
Urology input and any recommendations			
Last MSU / CSU result: Date: ____/____/____		Bacteria:	pH:
Sensitivities (if applicable):			
Type of sediment: ☐ Grainy ☐ Sandy ☐ Calcified appearance ☐ Mucousy appearance ☐ Blood clots			
Does the resident have a history of autonomic dysreflexia or spinal related complications?			
☐ Yes, state:		☐ No	
Initial Considerations (Click relevant)			
IDC dislodged (Catheter is no longer in correct position, i.e. partially pulled out)		☐ YES ☐ NO	
Catheter Mobile (catheter can move in and out without resistance)		☐ YES ☐ NO	
Signs of Current UTI (fever, pain, changes in behaviour or urine)		☐ YES ☐ NO	
Specific Considerations (Click relevant)			
☐ Trauma / Tampering	☐ Sediments / Clots	☐ Bag secured to lower leg / night bag	
☐ Dehydrated	☐ Recurrent Infection	☐ Urethral Meatal tear	
☐ Irregular Bowels / Constipation	☐ Frequent blocking	☐ Bag position	
☐ Anticoagulation therapy	☐ Bladder spasm	☐ Catheter kinked	
Documents required (Please attach to reply)			
Medication Profile	Medical History	Bowel Chart – Minimum 5 days	Fluid intake chart – Minimum 5 days

Once complete, please return to RCL@health.wa.gov.au with all requested documents above.
If you have any concerns or question, please call RCL on 6457 3146 0800-1800hrs, 7 days a week.

