WEEKLY DOCUMENTATION – FOLEY CATHETER

Resident Name: _____ **Date:** _____ **Time:** _____

Foley size: _____ Balloon size: _____

Color of urine: _____

Consistency of urine: _____

Odor: YES [ ] NO [ ] _____

Responsibility for catheter changes: (who) _____

How often: _____ Date of last change: _____

How did the resident tolerate catheter change? _____

Notes - Concerns: _____

_____

_____. **RN Signature:** _____

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