

Appendix 1

REQUEST FOR A NON-FORMULARY CATHETER/LEG BAG/NIGHT BAG PRODUCT

This form should be completed by the nurse with responsibility for the patient to document the reason for the use of a non formulary catheter.

Patient details

Name: CHI

Catheter requested

Catheter Name

Ch:

M/F

Balloon size

Code

Leg Bag Requested

Bag Name

Volume

Tube length

Code

Reason for alternative Catheter/Bag

Indication (please give brief description):

Reason why formulary product not suitable:

Name of Nurse

Date