

**District or Program
Toileting Assistance Log**

Student Name		DOB		School/District		Grade	
Parent/Guardian		Phone Number/s		Physician/NP/PA		Phone	
Order Start Date		Order End Date		IHCP on file		ICD-10 Code	

Date	Time started	Time done	Students position when toileting	Needed assistance or independent	Assistance with dressing/ adjusting clothing (Independent/ Needs Assistance Unsteady Other)	Appearance & estimated amount of stool: Formed Soft Hard Loose Watery Amount: Small Medium Large Color: Brown Yellow Orange	Appearance & estimated amount of urine: --Color (light or dark yellow, etc.) -- Light or heavy saturated --Unusual odor	Family or RN contacted: (Reason)	Care given by: (Initials)

I certify that the information provided on this form is true and accurate and that the services were provided in accordance with federal and state laws applicable to Medicaid. Delegation of nursing tasks is in accordance with the Colorado Nurse Practice Act. A copy of the Health Care Plan/IEP that authorizes these services for this student is available through the School District Medicaid Office.

Nurse/Delegator _____ **Nurse/Delegator Signature** _____ **Provider/procedure code: S01/X0205** **Date** _____
Please Print

Health Tech/Delegatee _____ **Tech/Delegatee Signature** _____ **Initials** _____ **Provider/procedure code: S18/X0225**
Please Print

Health Tech/Delegatee _____ **Tech/Delegatee Signature** _____ **Initials** _____ **Provider/procedure code: S18/X0225**
Please Print

Health Tech/Delegatee _____ **Tech/Delegatee Signature** _____ **Initials** _____ **Provider/procedure code: S18/X0225**

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