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**