BCG Instillation

Name:

Date of birth:

INSTILLATION EVERY 4TH WEEK

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| DATE |  |  | CYSTOSCOPY 4 WEEKS AFTER LAST INSTILLATION |  |  |  | CYSTOSCOPY 4 WEEKS AFTER LAST INSTILLATION |  |  |  | CYSTOSCOPY 4 WEEKS AFTER LAST INSTILLATION |  |  |  | CYSTOSCOPY 4 WEEKS AFTER LAST INSTILLATION |
| TREATMENT NUMBER | 1 | 2 | 3 | 1 | 4 | 5 | 6 |  | 7 | 8 | 9 | 1 | 10 | 11 | 12 |
| SIGNATURE |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| BLOOD TESTS  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| NORMAL |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| ABNORMAL – APPROVED BY PHYSICIAN |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| URINE DIPSTICK |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| NORMAL |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| ABNORMAL – APPROVED BY PHYSICIAN |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

* Remember to document the findings in the patient chart.
* See the local guideline about BCG instillation.
* Remember to hand out the patient information about BCG instillation.