Name_____
Rotation_____**Rotation Site**_____

UROLOGY CLERKSHIP

Please date and have a faculty or resident initial each encounter. ***This form must be completed and turned before the final exam can be taken!!***

Evaluation of Patients with the Following Known Diagnoses	**Date**	**Initials**	**Date**	**Initials**	**Date**	**Initials**
Benign Prostatic Hyperplasia (3)						
Prostate Cancer (3)						
Urinary Incontinence (3)						
Erectile Dysfunction (3)						
Urinary Calculi (3)						
Hematuria (3)						

Clinical Skills/Procedures	**Date**	**Initials**
Male Genital & Prostate Exam		
Placement of Foley Catheter (Male)		
Placement of Foley Catheter (Female)		

TOTAL NUMBER OF AMBULATORY PATIENTS PER ROTATION _____ (MINIMUM OF 30)

Please note, this does not apply to the Pediatric Urology rotation.