

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.*