**Physician’s Orders**

PRE-OPERATIVE KIDNEY TRANSPLANT RECIPIENT  
HT: ____________ cm  WT: ____________ kg  
Allergies: ____________________________________

<table>
<thead>
<tr>
<th>Date &amp; Time</th>
<th>PHYSICIAN’S ORDERS &amp; DIET</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Bullets Indicate to enter standard orders unless marked out</td>
</tr>
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<td>[ ] Boxes to be checked only if needed</td>
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<tr>
<td></td>
<td>Admit Patient To Transplant Service for Dr.:</td>
</tr>
<tr>
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<td>Diagnosis: Pre-operative kidney transplant</td>
</tr>
</tbody>
</table>

**Diagnostic Tests (STAT):**

1. CMP  
2. CBC  
3. PT/INR  
4. UA, if possible  
5. Type and Screen  
6. Serum HCG, If applicable  
7. EKG: indication: __________________________________________________________________|
8. CXR: ___________________________________________________________________________

Precoordinator Signature: ____________________________________________________________

Precoordinator Pager: ________________________________________________________________

Physician/NP Signature: _________________________ Physician ID Number: _________________

Physician Name Printed: _________________________ Physician Pager: _____________________

(place patient identification sticker here)