Physician Orders ADULT: Living Donor Transplant Nephrectomy Admit Plan

Initiate Orders Phase
Care Sets/Protocols/PowerPlans
- Initiate Powerplan Phase
  
  **T;N, Phase: Living Donor Transplant Nephrectomy Admit Phase, When to Initiate:**

Living Donor Transplant Nephrectomy Admit Phase
Admission/Transfer/Discharge

- Patient Status Initial Inpatient
  
  **T;N, Admitting Physician:** ________________________________

  **Reason for Visit:** ____________________________________

  **Bed Type: Med-Surg Specific Unit:** ____________________

  **Care Team:** __________________________________________

  **Anticipated LOS: 2 midnights or more**

Vital Signs
- Vital Signs Per Unit Protocol
  
  **T;N**

Activity
- Out Of Bed
  
  **T;N, Up As Tolerated**

Food/Nutrition
- NPO
  - Start at: **T;N, Instructions: NPO except for medications (DEF)**
  - Start at: **T;N**

Patient Care
- VTE MEDICAL Prophylaxis Plan(SUB)*
- Consent Signed For
  
  **T;N, Procedure: Donor Nephrectomy**

- Height
  
  **T;N, upon admission**

- Weight
  
  **T;N, upon admission**

- Intake and Output
  
  **T;N**

- SCD Apply
  
  **T;N, Apply To Lower Extremities**

- Nursing Communication
  
  **T;N, Pre-Donor evaluation workup to chart**

- Nursing Communication
  
  **T;N, If results not available in PACS, request CT Angiogram films delivered to O.R.**

- Nursing Communication
  
  **T;N, Notify Independent Living Donor Advocate of patient arrival**

Medications
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☐ +1 Hours ceFAZolin
   1 g, IV Piggyback, IV Piggyback, N/A, Routine
   Comments: Administer within 1 hour prior to incision in OR
   NOTE: If patient is allergic to penicillin/cephalosporin place order below:(NOTE)*

☐ +1 Hours vancomycin
   1 g, IV Piggyback, IV Piggyback, N/A, (infuse over 1 hr)
   Comments: Administer within 2 hours prior to incision in OR

Laboratory
☐ Type and Crossmatch PRBC
   STAT, T;N, 2 units, Type: Blood
☐ Transfuse PRBC’s - Not Actively Bleeding
   STAT, T;N
☐ Transfuse PRBC’s - Actively Bleeding
   STAT, T;N
☐ Hold PRBC
   STAT, T;N

Consults/Notifications/Referrals
☐ Notify Resident-Once
   T;N, Notify: Surgery Transplant Resident or Fellow on call, arrival to unit
☐ Notify Physician For Vital Signs Of
   T;N, Notify: surgery Transplant Resident or Fellow, BP Systolic > 130, BP Diastolic > 90, BP Systolic < 90, Heart Rate > 100, Heart Rate < 60, Oxygen Sat < 94
☐ Dietitian Consult/Nutrition Therapy
   T;N, Type of Consult: Other, please specify, Special Instructions: Nutrition Assessment
☐ Consult Clinical Pharmacist
   Start at: T;N
☐ Medical Social Work Consult
   T;N

Date ___________________  Time ___________________  Physician’s Signature ___________________  MD Number ___________________