**Physician Orders**  
**LEB Renal Biopsy Post Procedure Plan**

**PEDIATRIC**

T = Today; N = Now (date and time ordered)

<table>
<thead>
<tr>
<th>Height: ___________ cm</th>
<th>Weight: ___________ kg</th>
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**Allergies:** [ ] No known allergies

**Admission/Transfer/Discharge**

[ ] Admit Patient to Dr. T;N
[ ] Return Patient to Room T;N
[ ] Transfer Patient T;N

**Bed Type:** [ ] Med/Surg [ ] Critical Care [ ] Stepdown [ ] Telemetry; Specific Unit Location: 

[ ] Notify Physician Once T;N, of room number on arrival to unit

**Primary Diagnosis:** _____________________________

**Secondary Diagnosis:** _____________________________

**Vital Signs**

[ ] Vital Signs T;N, Monitor and Record T,P,R,BP, q15min x 4 occurrences, then q30min x 2 occurrences, then q4hr

**Activity**

[ ] Bedrest T;N, until AM then Activity as Tolerated, ad lib

**Food/Nutrition**

[ ] Clear Liquid Diet Start at: T;N

**Patient Care**

[ ] Advance Diet As Tolerated T;N, Start clear liquids and advance to regular diet as tolerated.

[ ] Nursing Communication T;N, Please save a sample of each urine overnight for visual inspection

**Medications**

[ ] Heparin 10 unit/mL flush 5 mL, (10units/mL),Ped Injectable, IVPush,prn, PRN Catheter Clearance, routine, T;N, peripheral or central line per nursing policy

[ ] acetaminophen ______ mg(10 mg/kg), Liq, PO, q4h, PRN Pain or Fever, T;N,Max Dose=90/kg/day up to 4 g/day

[ ] acetaminophen ______ mg(10 mg/kg), Supp, PR, q4h, PRN Pain or Fever, T;N,Max Dose=90mg/kg/day up to 4 g/day

[ ] acetaminophen 80 mg, chew tab, PO, q4h, PRN Pain or Fever, T;N,Max Dose=90 mg/kg/day up to 4 g/day

[ ] acetaminophen 325mg, tab, PO, q4h, PRN Pain or Fever, T;N,Max Dose=90 mg/kg/day up to 4 g/day

**Laboratory**

[ ] Hematocrit & Hemoglobin T;+240, routine, blood, once

**Consults/Notifications**

[ ] Notify Resident-Continuing T;N, For: hematuria or flank pain  Who: ____________________________

[ ] Notify Resident-Once T;N, Who: ____________________________, Reason: ____________________________

Date ________________  Time ________________  Physician's Signature ____________________________  MD Number ____________________________

41903 PP Renal Biopsy Post Procedure-QM-1108