



## Manitoba Renal Program Standing Orders for Transplant Referral

|   |   |                        |                                |
|---|---|------------------------|--------------------------------|
| <input checked="" type="checkbox"/> Standard Orders <input type="checkbox"/> Requires a check (✓) for activation  |   |                        |                                |
| These orders are to be used as a minimal standard and in conjunction with other Physician ordered blood tests.<br>Patient allergy and contraindications must be considered when completing these orders.<br>Additional testing or modification at the physician's discretion.   |   |                        |                                |
| Drug Allergies  | ORDER<br>TRANSCRIBED<br>AND<br>ACTIVATED  | Patient's Height _____ | DATE                      TIME |
|   |   | Patient's Weight _____ |                                |
| MEDICATION and INTRAVENOUS ORDERS   |   | TEST<br>DONE           | GENERAL ORDERS                 |
| <p>DATE _____ TIME _____</p> <p>-----</p> <p>If no history of tuberculosis or previous positive Mantoux, please administer:</p> <p><input type="checkbox"/> <b>2 step Mantoux</b></p> <ol style="list-style-type: none"> <li>1. Administer Tuberculin 5 test units (TU) intradermal. Read 48 - 72 hours after administration.</li> <li>2. If 1st step negative (less than 10 mm), administer 5 test units (TU) intradermal 7 - 28 days after 1st test. Read 48 - 72 hours after administration.</li> <li>3. Document readings in mm of induration.</li> <li>4. Send the dates given and results with the Transplant referral package. Please see "Request for Transplant assessment" form.</li> </ol> | <p><b>Diagnostic Tests</b></p> <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Chest X-ray, Posterior/Anterior and Lateral (completed within last 12 months)</li> <li><input checked="" type="checkbox"/> Electrocardiogram (completed within last 12 months)</li> <li><input checked="" type="checkbox"/> ABO Blood type</li> <li><input checked="" type="checkbox"/> Anti-HCV antibody, HBsAG, HBsAg antibody</li> <li><input checked="" type="checkbox"/> HIV Serology</li> <li><input checked="" type="checkbox"/> CBC</li> <li><input checked="" type="checkbox"/> Sodium, potassium, chloride, total CO<sub>2</sub>, urea, creatinine, total calcium, phosphate</li> <li><input checked="" type="checkbox"/> Liver enzymes (Albumin, T-Bilirubin, AST, ALT, ALP, GGT)</li> <li><input checked="" type="checkbox"/> PTH (completed within last 6 months)</li> </ul> |                        |                                |
| PHYSICIAN'S SIGNATURE _____ MD<br><br>PRINTED NAME _____ MD<br><small>GENERIC EQUIVALENT AUTHORIZED</small>   | TRANSCRIBED: _____ REVIEWER: _____<br><br><input type="checkbox"/> FAXED DATE: _____ TIME: _____ INITIALS: _____  |                        |                                |