PATIENTS NAME:

HOSPITAL NUMBER:

DATE OF BIRTH:

TRANSPLANT ON-CALL CHECK LIST

		Tick off
1	Advanced renal failure, serum creatinine usually over 1000 umol/l	✓
2	Negative hepatitis B antigen	neg
3	Tissue typing and blood group	
4	Pre-transplant transfusion (usually 1 unit packed cells x 3 at intervals of 3-4 weeks)	✓
5	Barium meal	[illegible]
6	Barium enema if over age 40 or bowel symptoms	[illegible]
7	Micturating cystogram	Yes
8	Metabolic skeleton	Yes
9	Additional Medical Problems: Hypertension	No
	Previous myocardial infarction	No
	Known ischaemic heart disease	No
	Peptic ulcer history	No
	Diverticular disease	No
	Diabetes mellitus	No
	Urological problem VUR + Ypkty	Yes
	Respiratory disease	No
	Infections	No
	Other:	—
	Smoker	—
10	CMV antibody ~~positive~~/negative	
11	On-call Booklet	