Full history and examination

Particular points of note:

a) History

- Cause of renal failure
- Dialysis:
    - type, when commenced, time of last dialysis â€“normal target or dry weight
    - access and any related problems
- Volume of urine output + history of past/present, urinary tract problems
- Infections -any recent urinary, CAPD peritonitis/exit site/access related
- Other operations
- Ischaemic heart disease
- Peripheral vascular disease
- Previous renal transplants, timing and cause of failure
- **Recipient** blood group, tissue typing and virology (CMV, EBV, HIV, Hep B & C) **must** be recorded in the notes.
- **Donor** details should also be included in recipient clerking – age, cause of death, blood group, tissue typing, virology and ischaemic time. The transplant coordinator will provide this information.

NOTE: Donor confidentiality must be maintained at all times

b) Examination – a full physical examination of the patient must be performed and should include:

- assessment of fluid status:
    - supine and erect blood pressure recordings
    - JVP
    - peripheries
    - any oedema
    - weight vs 'dry weight' if on dialysis
- peripheral pulses
- abdominal scars/hernias
- presence of failed transplant / previous transplant nephrectomy