Therapeutic Apheresis Orders(SCD non-Acute)

ospital: Roo		n#R	# Requested Date of Procedure		
Patient Name:		_ Patient MR#:		Date of Birth	
Height: Weight:		Gender [] Ma	ale [] Female	Blood Type	
Diagnosis: _ Sickle Cell non-Acute	Allergie	es:			
Consent(s) obtained?: For Proced	ure	For Blo	od Products:		
Contact Surgeon for Catheter Insertion: [] STAT		[] within	4 hrs. [x]b	y 8 AM next day	
Type of apheresis access (trialysis preferred) Order written for "Clear to use"					
Other significant diseases: [] Hear	t Disease Speci al Failure	fy [] Clotting/Bl	eeding Condition	[] Recent Surgery	
Apheresis Orders					
Type of Apheresis					
[x] Red Cell Depletion/Exchange[] Red Cell Exchange[] Red Cell Depletion		Plasmapheresis/Plasma ExchangePlateletpheresis/Platelet DepletionLeukapheresis/White Cell Depletion			
LifeSouth Community Blood Center	ers staff to perform	n therapeutic aph	eresis procedure(s	s) as follows:	
Frequency:	X_Once	2x Week	Every We	eeks	
	Daily	3x Week	Other:		
	EVENINGS AN	ID WEEKENDS	RESERVED FOR	EMERGENCIES ONLY	
Stop procedures when:	Target Hemoglobin S level is achieved				
Type of Anticoagulant:	[x]ACDA	[] None	[] Other		
Volume to be exchanged:	[] 1.0X	[x] Other	As needed to achie	eve target Hgb S	
Fluid balance:	[x]100%	[] other		_%	
Blood Prime:	[x]No	[] Yes, if <25	kg) []	other	
Replacement Fluids:					
[] 5% Albumin		mL []FFP		_ units	
[] Albumin 5% with r	ormal saline (2:1	ratio as tolerated	<i>أ</i>	mL	
[x] PRBCs5-8	_Hgb S neg_units	[x] NS	G [] Cryo-po	oor plasmamL	
Telemetry: [x] (recommended	d if receiving bloo	d components or	have known CV ris	sk factors)	

AM Labs: (0400 lab draw) each day of apheresis procedures: [x]BMP [x]Ionized Calcium []LDH [] Haptoglobin [x]CBC [] Peripheral smear for Schistocyte count Order the following if Albumin or Cryopoor plasma is utilized as replacement fluid: As Needed Labs: IF TTP SUSPECTED: [] Type & Screen [] AdamTS13 (Routine) [] AdamTS13 (STAT) [] retic count [] Indirect Billirubin [] DAT/Coombs []LDH IF SICKLE CELL: [x] Hgb electrophoresis [x] Type & Cross If applicable: (Sickle Cell patients only) End target Hct: _____30%____ Beginning Hct: Initial or estimated HgS: _____100%_____ End target HgS: ____30%____ If RBC Depletion requested: Target Hematocrit____ **Medications:** D/C ACE Inhibitors if using Albumin as replacement fluid (Date and time of last dose) x Acetaminophen 650mg PO Pre Apheresis. If unable to tolerate PO, may give per Rectum. x Acetaminophen 650mg PO Every 4 hours PRN Reaction. If unable to tolerate PO, may give per Rectum. x_Diphenhydramine 25mg PO/IV Pre Apheresis. If unable to tolerate PO, may give IV. x_Diphenhydramine 25mg PO/IV Every 4 hours PRN Reaction. If unable to tolerate PO, may give IV. _Diphenhydramine 50mg PO/IV Pre Apheresis. If unable to tolerate PO, may give per Rectum. __Diphenhydramine 50mg PO/IV Every 4 hours PRN Reaction. If unable to tolerate PO, may give per Rectum. x Calcium Gluconate 2 Gms IV over 30 to 60 minutes. May repeat x __1_PRN Calcium Gluconate 4 Gms IV over 30 to 60 minutes. May repeat x PRN x_Oxygen 2-4 L per NC for O₂ saturation less than 90% (have available at bedside prior to treatment) To be administered by hospital nursing staff: Lorazepam (ATIVAN) 0.5 to 1 mg PO/IV every 4 hours PRN for anxiety prior to and/or during apheresis x_Methylprednisone (SOLUMEDROL) 125 mg IV PRN for allergic reaction. Ensure readily available for emergency. Other: Other Comments or orders:

Physician signature/ Date/ time

Physician ID #

Physician contact Tel #

Lab Specimens:

Physician Name