Therapeutic Apheresis Orders(SCD Crisis)

Hospital: ______________________________ Room # _______ Requested Date of Procedure________________

Patient Name: _______________________________ Patient MR#:_________________ Date of Birth________

Height: _______ Weight: ________ Gender [ ] Male [ ] Female Blood Type __________

Diagnosis: _ Sickle Cell Crisis(Acute Stroke, Severe Chest Syndrome)____ Allergies: _____________________________

Consent(s) obtained?: For Procedure_______ For Blood Products: __________

Contact Surgeon for Catheter Insertion: [x] STAT [ ] within 4 hrs. [ ] by 8 AM next day

Type of apheresis access (trialysis preferred) _____________________ Order written for “Clear to use” _________

Other significant diseases: [ ] Heart Disease Specify ____
[ ] Renal Failure [ ] Clotting/Bleeding Condition [ ] Recent Surgery

Apheresis Orders

Type of Apheresis

[ ] Red Cell Depletion/Exchange
[x] Red Cell Exchange
[ ] Red Cell Depletion
[ ] Plasmapheresis/Plasma Exchange
[ ] Plateletpheresis/Platelet Depletion
[ ] Leukapheresis/White Cell Depletion

LifeSouth Community Blood Centers staff to perform therapeutic apheresis procedure(s) as follows:

Frequency: X_Once __2x Week __Every ____ Weeks
__Daily __3x Week __Other: __________

EVENINGS AND WEEKENDS RESERVED FOR EMERGENCIES ONLY

Stop procedures when: __RBC volume exchange is complete________________________

Type of Anticoagulant: [x] ACDA [ ] None [ ] Other________________

Volume to be exchanged: [ ] 1.0X [x] Other _As needed to achieve 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 normal saline (2:1 ratio *as tolerated*) ___________________mL

[x] PRBCs _5-8_Hgb S neg_units [ ] NS [ ] Cryo-poor plasma _____________mL

Telemetry: [x] (recommended if receiving blood components or have known CV risk factors)

Lab Specimens:

AM Labs: (0400 lab draw) each day of apheresis procedures:

[x] CBC [x] BMP [x] Ionized Calcium [ ] LDH [ ] Haptoglobin

[ ] Peripheral smear for Schistocyte count

Order the following if Albumin or Cryopoor plasma is utilized as replacement fluid:

[ ] PT/PTT [ ] Fibrinogen [ ] Other (list): ____________

As Needed Labs:

IF TTP SUSPECTED: [ ] Type & Screen [ ] AdamTS13 (Routine) [ ] AdamTS13 (STAT)

[ ] LDH [ ] retic count [ ] Indirect Billirubin [ ] DAT/Coombs

IF SICKLE CELL: [x] Hgb electrophoresis [x] Type & Cross

If applicable: (Sickle Cell patients only)

Beginning Hct: ___________________ End target Hct: ____________________

Initial or estimated HgS: ______100%_____________ End target HgS: _____30%_____________

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 O_2 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: ____

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Other Comments or orders:

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Physician Name	Physician signature/ Date/ time	Physician ID #	Physician contact Tel #