

Therapeutic Apheresis Orders

Hospital: _____ Room # _____ Requested Date of Procedure _____

Patient Name: _____ Patient MR#: _____ Date of Birth _____

Height: _____ Weight: _____ Gender Male Female Blood Type _____

Diagnosis: _____ Allergies: _____

Consent(s) obtained?: For Procedure _____ For Blood Products: _____

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

Type of apheresis access (trialsysis 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

- | | |
|--|--|
| <input type="checkbox"/> Red Cell Depletion/Exchange | <input type="checkbox"/> Plasmapheresis/Plasma Exchange |
| <input type="checkbox"/> Red Cell Exchange | <input type="checkbox"/> Plateletpheresis/Platelet Depletion |
| <input type="checkbox"/> Red Cell Depletion | <input type="checkbox"/> Leukapheresis/White Cell Depletion |

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

Frequency: _____Once _____2x Week _____Every _____ Weeks
_____Daily _____3x Week _____Other: _____

EVENINGS AND WEEKENDS RESERVED FOR EMERGENCIES ONLY

Stop procedures when: _____

Type of Anticoagulant: ACDA None Other _____

Volume to be exchanged: 1.0X Other _____

Fluid balance: 100% other _____%

Blood Prime: No Yes, if <25 kg) other _____

Replacement Fluids:

5% Albumin _____ mL FFP _____ units

Albumin 5% with normal saline (2:1 ratio as tolerated) _____ mL

PRBCs _____ units NS Cryo-poor plasma _____ mL

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

Lab Specimens:

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

- CBC with diff BMP 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: Hgb electrophoresis Type & Cross

If applicable: (Sickle Cell patients only)

Beginning Hct: _____ End target Hct: _____
Initial or estimated HgS: _____ End target HgS: _____

Medications:

- __ D/C ACE Inhibitors *if using Albumin as replacement fluid* (Date and time of last dose _____)
- __ Acetaminophen 650mg PO Pre Apheresis. If unable to tolerate PO, may give per Rectum.
- __ Acetaminophen 650mg PO Every 4 hours PRN Reaction. If unable to tolerate PO, may give per Rectum.
- __ Diphenhydramine 25mg PO/IV Pre Apheresis. If unable to tolerate PO, may give IV.
- __ 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.
- __ Calcium Gluconate 2 Gms IV over 30 to 60 minutes. May repeat x _____ PRN
- __ Calcium Gluconate 4 Gms IV over 30 to 60 minutes. May repeat x _____ PRN
- __ 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 mg PO/IV every 4 hours PRN for anxiety prior to and/or during apheresis
__ Lorazepam (ATIVAN) 1.0 mg PO/IV every 4 hours PRN for anxiety prior to and/or during apheresis
__ Methylprednisone (SOLUMEDROL) 125 mg IV PRN for allergic reaction. Ensure readily available for emergency.
__ Other: _____

Other Comments or orders:

Physician Name

Physician signature/ Date/ time

Physician ID #

Physician contact Tel #