

Therapeutic Apheresis Orders(Renal Hemorrhagic)

Hospital: _____ Room # _____ Requested Date of Procedure _____

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

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

Diagnosis: _ ANCA Wegener's/Goodpaster's with DAH _____ Allergies: _____

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

Contact Surgeon for Catheter Insertion: [] STAT [x] 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 checked="" 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 X_Other: Daily x3, then 3x a week _____

EVENINGS AND WEEKENDS RESERVED FOR EMERGENCIES ONLY

Stop procedures when: a total of 6-9 procedures _____

Type of Anticoagulant: [x] ACDA [] None [] Other _____

Volume to be exchanged: [x] 1.0X [] Other _____

Fluid balance: [x] 100% [] other _____%

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

Replacement Fluids:

[] 5% Albumin _____ mL [x] FFP _____ 2 _____ units

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

[] PRBCs _____ 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:

[x] PT/PTT [x] Fibrinogen [x] Other (list): Type & Screen _____

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:

x_ 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.
__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

__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

x_Methylprednisone (SOLUMEDROL) 125 mg IV PRN for allergic reaction. Ensure readily available for emergency.

x_Oxygen 2-4 L per NC for O₂ saturation less than 90% (have available at bedside prior to treatment)

__Other: _____

Other Comments or orders:

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