Therapeutic Apheresis Orders(Neurological)

Hospital: _____ Room # _____ Requested Date of Procedure_____

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

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

Diagnosis: _Myasthenia Gravis/NMO/Guillain Barre/CIDP_____ Allergies: _____

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

Contact Surgeon for Catheter Insertion: [ ] STAT [ ] within 4 hrs. [X] 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
[ ] Red Cell Exchange
[ ] Red Cell Depletion
[X] Plasmapheresis/Plasma Exchange
[ ] Plateletpheresis/Platelet Depletion
[ ] Leukapheresis/White Cell Depletion

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

Frequency: __Once __2x Week __Every ____ Weeks

__Daily X_3x Week __Other: _____

EVENINGS AND WEEKENDS RESERVED FOR EMERGENCIES ONLY

Stop procedures when: __Re-evaluate after 2 weeks _____

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 [ ] FFP _____ 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:

[ ] 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:

x_ 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. per Rectum.

__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

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

x_Oxygen 2-4 L per NC for O_2 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 #