MRI Number

REQUEST FOR THERAPEUTIC APHERESIS PROCEDURE

Registration No. 2000/026390/08

Please print legibly as this is a medical legal document.
I hereby request the South African National Blood Service to perform a therapeutic procedure (or series of procedures) on the following patient.

Name of Patient							
Date of Birth		Gender		Height			
Age		ID No		Weight			
Diagnosis				ICD Code			
Hospital		Hospital Number		Ward			
Medical Aid Society		Primary member / dependant:					
	Medical Aid No:			Dependant Code:			
Address							
Contact No (Home)		Work		Cell			
Procedure Required				ABO and Rh			
Central line (indicate)	Size		Type		Site		
Allergies							
First Procedure (date)		Frequency (indicate)		Daily	Alternate day	Other:	
Plasma Volume Exchange		Estimated Number of Procedures					

Desired Fluid Replacement: (Tick the applicable fluid)

4% Albusol solution		FFP		Cryo Poor Plasma		Other	
Attending physician Name and Surname				Signature			
Red cell exchange procedures	End Haematocrit			Desired Fraction of Cells Remaining			

Transfusion History

Has the patient received blood or blood component transfusions before?	Y	N
Is there a history of transfusion related reaction?	Y	N
Describe transfusion reaction (Type of reaction / blood product involved)		

Name of Patient		Date of Birth	

Laboratory Results: Day 1 of procedure						
HB		Red cell fragments		Neutrophil count / %		
Haematocrit (HCT)		Urea		Lymphocyte count / %		
WCC		Creatinine		Monocyte count / %		
Platelets		GFR		Basophil count / %		
LDH		GCS		Eosinophil count / %		
Corrected Ca++		GBS ds		RVD	+	-
Ionized Ca++		pO_2		HBV	+	-
Mg++		FiO_2		HCV	+	-
Other		LDL cholesterol		Other		

1. Please schedule medication (especially antibiotics and plasma-bound drugs) to be administered post-

Medication on first day of procedure			
Medication	**Dosage**	**Route**	**Frequency**

exchange when possible.

2. It is recommended that ACE inhibitors be discontinued for 48-72 hours prior to therapeutic plasma exchange procedures. For patients with impaired liver and renal functions additional time is recommended.

3. Please notify the Apheresis Staff if the procedure is cancelled or the patient's condition changes.

4. Please note completion of the necessary documentation is **a medico legal requirement** and any delays in the completion of the paperwork will result in delays in the procedures.

CHECKLIST	
Patient details	Weight (daily for duration of procedures).
Documents	Completion of consent form.
	Completion of request form.
Patient location	Patient must be in bed at designated time of procedure.
	For dialysis patients: please inform therapeutics practitioner at what time dialysis procedure will be performed.
Ward / cubicle	Working light source.
	Working water supply.
	Working electricity supply.
	Working oxygen supply.
	Working suction supply.
Central venous catheter (CVC)	Minimum of 11.5 Fr for adults.
	If subclavian or internal jugular veins, CXR-based confirmation of position of CVC and exclusion of a pneumothorax. **NOTE: It is the responsibility of the attending physician to ensure correct placement of the central venous catheter.**
Blood products	Requested from blood bank as urgent.
	For TTP, blood products requested for at least 10 days from start of procedure.
Blood results: Daily for TTP	FBC and smear.
	Calcium.
	LDH.
	U&E and creatinine.

Name of Patient		Date of Birth	

STANDING ORDERS FOR EMERGENCY TREATMENT OF ADVERSE EFFECTS DURING THERAPEUTIC PLASMA EXCHANGE

Standing orders for the treatment or prevention of adverse effects during therapeutic plasma exchange procedure are reviewed by the Apheresis Lead Consultant. The Apheresis Staff and/or the Apheresis Consultant and the attending physician must be notified, as soon as possible, of any adverse reaction that occurred after the procedure.

1. Allergic reactions

a) Pre-medication for patients with a history of allergic reactions:

i) If a patient has a history of hives or urticarial reactions when receiving blood products, pre-medicate the patient with 12.5mg diphenhydramine (e.g. Phenergan) intravenously.

ii) If the patient has a history of severe allergic reactions, pre-medicate the patient with 12.5mg - 25 mg Promethazine hydrochloride (e.g. Phenergan) and hydrocortisone 100mg (e.g. Solu-Cortef) or equivalent dose of other available intravenous steroid.

b) Onset of allergic reactions (mild-moderate) during procedure:

i) Pause the procedure, open saline line, monitor vital signs, connect patient to a pulse oximeter (if available). Administer oxygen at 5-10L/min. Call attending physician. Administer 12.5-25mg Promethazine hydrochloride (e.g. Phenergan) and hydrocortisone 100mg (e.g. Solu-Cortef) or equivalent dose of other available intravenous steroid.

ii) Notify Apheresis Lead Consultant.

2. Citrate toxicity or hypocalcaemia

a) Patients that have daily therapeutic plasma exchanges performed should have ionized calcium or a total and corrected calcium level tested.

b) In a patient presenting with an ionised calcium level less than 1 mmol/L or a corrected calcium count less than 2 mmol/L, intravenous calcium should be administered (e.g. administer 1 ampoule calcium gluconate IV over three minutes and administer 1 ampoule calcium gluconate 10% in a 250ml saline over 2-3 hours during the procedure).

c) A patient presenting with ionised calcium count of 1.1 mmol/L or corrected calcium count less than 2.15 mmol/L, administer 1 ampoule calcium gluconate in a 250ml saline over 2-3 hours during the procedure.

d) If a patient presents with symptoms of mild hypocalcaemia, administer 1gram of oral calcium gluconate (e.g. Calcium Sandoz). Dose can be repeated prn x2.

e) If a patient develops moderate to severe hypocalcaemia, administer 1 ampoule of calcium gluconate 10% in a 50ml saline solution over 10 minutes. Alternatively, administer calcium by slow intravenous (IV) push.

f) Intravenous calcium must be administered through a different IV line to the line used for the apheresis procedure. If no alternate line is available, the procedure must be paused, the calcium administered and the line flushed with saline solution, before continuing the procedure.

Agreement by attending physician

I have medically examined the patient and undertaken the relevant laboratory investigations and I consider the patient will tolerate the procedure without any significant untoward reaction.

I understand that the technical procedure is being undertaken by the staff of SANBS. I have made arrangements for emergency medical care should it be necessary. I authorise the administration of medication routinely used during this type of procedure. I understand that I as the attending physician primarily remain responsible for the medical management of the patient and must be available for consultation during the therapeutic apheresis procedure, or in the event of any untoward reaction.

_____	_____
Name of Responsible Physician	*Signature*

_____	_____	_____
Practice Number	*Date*	*Contact Number*