Clear Fields

LIFESOUTH Community Blood Centers

Therapeutic Apheresis Orders

Hospital:		Room #:
Requested Date(s) of Procedure:		
Patient Name:		Patient MRN:
Date of Birth:		Sex: ☐ Male ☐ Female
Height:	Weight:	Blood Type:
Diagnosis:		
MD consent(s) obtained? ☐ For procedure ☐ For blood products		
Contact surgeon for catheter insertion: ☐ STAT ☐ Within 4 hrs ☐ By 0800 next day		
Type apheresis access*: _____ *Hemodialysis catheter (e.g., Vascath, Quinton, or Trialysis) is recommended to accommodate high flow rates. CVC, Swan-Ganz, and PICC are not suitable access types.		
Order written for catheter "Clear to use?" ☐ N/A ☐ Yes; Date/Time: _____		
Other significant diseases: ☐ Renal Failure ☐ Clotting/Bleeding Condition ☐ Recent Surgery ☐ Heart Disease, specify: _____		

Apheresis Orders

Type of Apheresis:
☐ Red Cell Depletion/Exchange ☐ Plasmapheresis/Plasma Exchange
☐ Red Cell Exchange ☐ Plateletpheresis/Platelet Depletion
☐ Leukapheresis/White Cell Depletion ☐ Other: _____

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

Frequency*: ☐ Once ☐ Every other day ☐ Weekly
☐ Every ____ weeks ☐ Custom (see requested dates above)

***EVENINGS AND WEEKENDS RESERVED FOR EMERGENCIES ONLY**

Criteria for ceasing procedures:

Type of Anticoagulant: ☐ ACDA ☐ None ☐ Other: _____

Volume to be Exchanged: ☐ 1.0X ☐ 1.5X ☐ Other: _____

Fluid Balance: ☐ 100% ☐ Other: _____

Blood Prime: ☐ No ☐ Yes, if < 25 kg ☐ Other: _____

Replacement Fluids*: ☐ 5% Albumin: _____ mL ☐ NS
☐ pRBC: _____ units ☐ FFP _____ mL ☐ Cryo-poor plasma: _____ mL

*Recommend using Terumo BCT RBCX Calculation Tool for red cell exchanges and www.mdcalc.com/blood-volume-calculation for replacement plasma volumes.

☐ Telemetry *(Recommended if receiving blood components or have known cardiovascular risk factors.)*

Lab Specimens

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

☐ CBC ☐ BMP ☐ Ionized Calcium

Order the following if Albumin or Cryo-poor plasma is utilized as replacement fluid:

☐ Fibrinogen ☐ Other (list): _____

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Patient Name:	Patient MRN:	Date of Birth:

Lab Specimens (Continued)

As Needed Labs:

If TTP Suspected: ☐ Type & Screen ☐ ADAMTS13 activity with reflex inhibitor

If Sickle Cell: ☐ Type & Cross ☐ Hgb electrophoresis (Pre) ☐ Hgb electrophoresis (Post)

If applicable *(Sickle Cell patients only)*:

Beginning Hct:	End target Hct:
Initial or estimated Hgb S:	End target Hgb S:

Medications

☐	D/C ACE Inhibitors *if using Albumin as replacement fluid.*	Date and time of last dose:

☐	Acetaminophen 650 mg PO Pre-Apheresis. If unable to tolerate PO, may give per rectum.
☐	Acetaminophen 650 mg PO Every 4 hours PRN Reaction. If unable to tolerate PO, may give per rectum.

☐	Diphenhydramine 25 mg PO/IV Pre-Apheresis. If unable to tolerate PO, may give IV.
☐	Diphenhydramine 25 mg PO/IV Every 4 hours PRN Reaction. If unable to tolerate PO, may give IV.

☐	Diphenhydramine 50 mg PO/IV Pre-Apheresis. If unable to tolerate PO, may give IV.
☐	Diphenhydramine 50 mg PO/IV Every 4 hours PRN Reaction. If unable to tolerate PO, may give IV.

☐	Calcium Gluconate 2 g IV over 30 to 60 minutes. May repeat x _____ PRN.
☐	Calcium Gluconate 4 g IV over 30 to 60 minutes. May repeat x _____ PRN.

☐	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.

☐	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. #	Secondary Contact Tel. #

Fax completed form to 352-224-1778.