Addressograph or Patient ID Label

Therapeutic Hemapheresis Procedure

Date/Time:_________________

Patient Name:____ DOB:________________

Hospital:___________________________________ Allergies: _______________________________________ ☐ NKA

Diagnosis:_________________________________ Clinical Indications:______________________________________

Treatment Protocol and Replacement Fluid *(check one procedure type and product, indicating volume):*

☐ **Plasma Exchange**: *(1.25volume exchange ~ 45 ml/kg)*
- ☐ _________mL 5% Albumin
- ☐ _________mL Frozen Plasma
- ☐ _________mL Cryoprecipitate Reduced Plasma

NOTE: Discontinue ACE Inhibitors 48 hours prior to treatment with Albumin. If treatment required within 48 hours use Plasma as an alternate replacement fluid.

☐ **RBC Exchange**: (*Adults ~ 8-10 units, Pediatrics ~ 4 units*)
- ☐ _________units PRBC Desired Ending Hct%___________, Desired Ending HbS%_________
- Special product requirements (i.e., sickle cell negative, CMV safe)_____________________________________

☐ **Reduction**:
- ☐ **RBC Reduction**: Desired Ending Hct%_______________
- ☐ **WBC Reduction**: Desired Ending WBC ______________ Process 2X patient's total blood volume.
- ☐ **Platelet Reduction**: Desired Ending Plt count__________ Process 2X patient's total blood volume.
- ☐ **Replacement fluids to be administered** ☐ None Required ☐ _________ mL ___________________(type)

☐ **Blood Prime**: *(Pt. Hct <15 and/or weight <50 lbs.)* Type and crossmatch one unit PRBC for Blood Prime

Frequency:__________________**Duration**:_____________________ (inpatient orders must be renewed every 7 days)

Labs:☐ None required ☐ ____(specify)

Medications (to be administered by Hospital Staff): ☐ None required
- ☐ Benadryl _________mg Route of Administration ___________
- ☐ Tylenol __________mg Route of Administration___________
- ☐ Other:____(specify)

Calcium Gluconate (prevents citrate reaction – administered by Hospital Staff): ☐ None required
- *Infuse IV over entire apheresis procedure. Consult with ARC nurse to determine length of procedure.
- ☐ 1 gram in 100 mL Normal Saline*
- ☐ 2 grams in 200 mL / 250 mL Normal Saline*
- ☐ Other pediatric dose____

Flush for Central Line/Port Device:
- ☐ 10,000 units Heparin (5000 units/ml each lumen standard minimum concentration for Adults)
- ☐ 2,000 units Heparin (1000 units/ml each lumen standard pediatric concentration)
- ☐ Other____

Special conditions (e.g., coordinate treatment with dialysis, delay/hold medications)

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Contact American Red Cross Therapeutic Apheresis Department to schedule treatment.
For Atlanta, please call 770-852-4430 or 1-800-884-2710 ext. 4430. For Savannah, please call 1-800-507-2184.

Physician Name:(print)____ Office Phone:______________________

Physician Signature: ______________________________________Cell Phone or Pager:______________________

Verbal Order Documented by ____ Hospital Staff Signature/Title