*Fields preceded by italicised prompts can be completed electively*

Addressograph label (if available)

|  |  |
| --- | --- |
| **Patient Name:** | **Ward (if inpatient):** |
| **Address:** | **Ward contact no:** |
|  | **Named nurse:** |
| **DOB:** | **Named (‘immediate care’) doctor:** |
| **CHI no:** | **Contact No:** |
| **Referring hospital:** | ***GP details:*** |
| **Speciality:** | ***Name:*** |
| **Referring Consultant:** | ***Address:*** |
| **Contact No:** |  |
| **Date, time of referral:** |  |
| **Diagnosis:** | ***Next of Kin Name:*** |
| **ASFA Category:** | ***Contact No:*** |

|  |  |  |
| --- | --- | --- |
| **Planned procedure (delete): TPE / RBCX / other\*** | **Height (cm)** | **Weight (kg)** |
| **\*Details:** | **Allergies:** | |
| **Brief history:** |  |  |
| *Smok er NO / YES / ..................../ day* | | |
| *Alcohol NO / YES / .......... units / wk* | | |
| **Relevant PMH:** | | |
| **Current medications:** | | |
| **Any relevant family / social history:** | | |

YES / NO

**Referral accepted:**

|  |  |
| --- | --- |
| **Peripheral venous access:** YES / NO | **If No, has line placement been organised –** YES / NO |

# Bloods required for all apheresis procedures

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| DATE: | | | | | | |
| Hb\* | Hct\* | Plats\* | WBC | Fib\* | Ca\* | Mg |
| ALT | LDH | Blood grp\* | neuts | lymphs | Trop T | Ur |
| Cr\* | Na\* | K\* | Bili | Alk phos | Alb | INR |
| APTT\* | PT\* | HbS |  |  |  |  |

Pregnancy test **\*** (if applicable): Y / N

**\*** *Asterisked tests are mandatory for* ***all*** *referrals and will be required before treatment commences*.

*The other fields may or may not be required depending on clinical circumstances (e.g. LDH is mandatory in TTP,*

***PRE & POST*** *HbS is mandatory for RBCX)*.

# Exchange targets for RBCX

|  |  |
| --- | --- |
| Recommended Hct target: **see below\*** | Recommended HbS target: **15%** |
| Hct: | HbS: |

**\*** Hct target 30%±3 but should not be raised more than 2% from baseline. If patient requires top up transfusion to

correct anaemia this should be performed separately before or after exchange procedure.

|  |  |
| --- | --- |
| Temp. | oC |
| Pulse: | /min |
| BP: | mmHg |
| Resp. rate: |  |

**\*\*** Clinician to decide on HbS% target. If it is felt that 15% would be too much to achieve in one procedure, target can be set to 30% and RBCX can be repeated the following day as indicated by post procedure blood results.

## Physical Examination (Including Baseline Observations)

NEWS Score: Is conscious level reduced? YES/NO If YES, current GCS:

Is patient fit to proceed with planned procedures? YES/NO

CONSENT FOR PROCEDURE YES/NO

If NO, ‘Adults With Incapacity Act’ certification in place? YES/NO

*INFORMATION BOOKLET GIVEN* YES/NO

***Can patient travel to unit? YES/NO If YES – transport arrangements*:**

# Referral acceptance

Signature of doctor / nurse \* accepting referral:

Print name (block capitals): Date:

If nurse accepting referral, name of doctor from whom over-the-phone referral has been taken: If local doctor assessed patient, signature of doctor:

Name of doctor who assessed patient (block capitals): Date:

* Delete as appropriate

# Treatment details

**Treatment urgency:** Acute (within 4 hours) / Elective (next available slot) \*

* Delete as appropriate

**Replacement fluid (delete):** 50:50 5% albumin – Gelofusine / Octaplas / FFP / RCC

**Approx replacement volume per procedure:** plasma volume(s) or mls/kg body wt

**‘Special’ requirements (delete):** irradiated / CMV neg / HEV neg

## Planned number of procedures: Frequency:

**Increased risk of haemorrhage (delete) YES / NO Date of renal biopsy**

**NOTE BELOW ANY SPECIAL PRECAUTIONS TO BE TAKEN DURING APHERESIS PROCEDURE**

**Details:**

**Sign:**

**Treatment Update**

**Date:**

**Details:**

**Sign:**

**Procedural Change**

**Date:**