NATF 1052 03

(Relates to SOP No. NATS CLIN APH 017

Therapeutic Apheresis: New Patient Referral and Assessment Form

Addressograph label (if available)

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

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

NATF 1052 03

(Relates to SOP No. NATS CLIN APH 017

Therapeutic Apheresis: New Patient Referral and Assessment Form

Referral accepted: YES / NO	**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*	Hb_S				
Pregnancy Test* (if applicable): Y / N			If Yes – Result: Positive / Negative			

***** *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).*

Recommended Hct target: **see below***	Recommended Hb_S target: **15%**
Requested post Hct:	**Requested** post Hb_S:

***** 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.

****** Clinician to decide on Hb_S% 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)

Temp: _____ °C
Pulse: _____/min
BP: _____mmHg
Resp rate: _____/min

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*:**

NATF 1052 03

(Relates to SOP No. NATS CLIN APH 017

Therapeutic Apheresis: New Patient Referral and Assessment Form

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

Treatment Update	**Procedural Changes**
Date: **Sign:**	**Date:** **Sign:**
Details:	**Details:**