1.1. Patient Assessment Form for Therapeutic Plasma Exchange

– to be completed by the Transfusion MO/ Specialist or Haematologist

Diagnosis: _____Physician in Charge/Beeper: _____

Approved Condition: Y / N

Reason for acceptance if not approved condition: _____

Consent process – Indications for pheresis – CHL Clinician. CHL Consent form completed or entry made in notes

The plasmapheresis procedure – NZBS Consent form for Therapeutic Plasmapheresis

Blood Products – CHL Clinician to get blood products consent form signed

Central venous line – either CHL consent form or an entry in the notes CHL Clinician who inserts the line to do this.

History of Present Illness and Review of Systems: (list any major problems)

_____

Vascular Access:___

Query needs insertion of a hard-walled central renal dialysis catheter: Y / N
The referring medical team to arrange this

Blood Transfusion History: _____ Allergies:_____

Weight _____Kg. Height _____cm. BSA _____m^2

Baseline Laboratory tests (CBC, Na, K, Creatinine)Signed_____ Date _____

Treatment Plan/Special Considerations:

Pheresis Schedule, replacement fluid, list any blood tests required pre and post.		
Approved Indications For Therapeutic Plasmapheresis		
Neurology	**Renal**	**Haematology**
Guillian-Barre synd I	Goodpastures synd **	TTP* I
CIDPN I	Lupus nephritis **	HUS/HELLP (post partum) * II
Myasthenia gravis I	Pauci-immune RPGN ** II	Hyperviscosity I
Lambert-Eaton myasth. Synd. II	**Rheumatic Disorder**	Cryoglobulinaemia I
Metabolic	Vasculitis II	Cold agglutinin disease I
Hypercholesterolaemia I	**Drug overdose/poisoning** (drug highly protein bound) ** II	
Note: I = Standard therapy, **II** = accepted adjuvunctive therapy Replacement Fluids: crystalloid and colloid (4% albumin); exceptions * FFP/Cryosupernatant ** 4% Albumin		