

Apheresis Request

Request Date: _____ Patient Name: _____ DOB: _____

Hospital: _____ Room #: _____ (_____) _____
Nurse's Station Phone #

Diagnosis: _____ Sex: M F Ht: _____ Wt: _____

Ordering Physician: _____ Office Phone # _____ Pager # _____

Patient home/cell number: _____ MRN: _____

Is patient able to sign Consent? **Yes No** (If No, assure guardian is available at first procedure)

Chest Pain/
Heart Attack **Yes No** Date/Frequency: _____ Uses Nitro? **Yes No**
If Yes, frequency taken: _____

Heart Condition/
Surgery **Yes No** Date/Type: _____

Diabetes/
Renal Disease **Yes No** Controlled by: Diet / Oral / Injection

Lung Disease **Yes No** Condition: _____ Uses O₂? **Yes No**

Allergies to
Medications **Yes No** Allergic to: heparin / psoralen / figs / parsnips / limes / tape / chloraprep / betadine /
celery / ethylene oxide / latex

Reaction to
Blood Products **Yes No** Nature of reaction: _____

On ACE-
inhibitors **Yes No** Last dose: _____

Other medical conditions (include prior apheresis, pregnancy, clotting disorder, photo sensitive): _____

Medications: _____

Has type and screen been performed? **Yes No N/A** Patient ABO type: _____

Has pheresis catheter been placed?
or peripheral access adequate? **Yes No N/A** Type and location: _____

Catheter placement confirmed, if needed? **Yes No N/A** Placement OK'd by: _____

Current Labs: Hgb/Hct _____ Ca/ion Ca++ _____ Creatine _____
WBC _____ PT/INR/PTT _____ BUN _____
Plt _____ Bilirubin _____ K⁺ _____
LDH _____ Fibrinogen _____ RBC morph _____

Comments: _____

Completed by (initials/date) _____ MD Verbal Approval / Date _____