REQUEST FOR LEUKAPHERESIS

Registration No. 2000/026390/08

Please print legibly as this is a Medico-legal document.
I hereby request the South African National Blood Services to perform a Leukapheresis (or series of procedures) on the following study participant.

Study Participant								
Date of Birth			Gender		Height			
Age			ID No		Weight			
Diagnosis					ICD CODE			
Hospital			Hospital Number		Ward			
Medical Aid Society				Primary member/ dependant				
	Medical Aid No:			Dependant Code				
Address								
Contact No (Home)		Work			Cell			
Procedure Required					ABO and RH			
Central line (indicate)	Size		Type		Site			
Allergies								
First Procedure (date)		Frequency (indicate)		Daily	Alternate Day		Other:	
Blood Volume to be processed		Estimated Number of Procedures						

Laboratory Results

Date of Results (no older than 72 hours)						
***Haemoglobin (Hb)**		***Potassium (K)**		**Neutrophil count /%**		
***Haematocrit (Hct)**		**Urea**		**Lymphocyte Count/%**		
***WCC**		**Creatinine**		**Monocyte count/%**		
Platelets		**GFR**		**Basophil count/%**		
***Corrected Ca++**		**GCS**		**Eosinophil count/%**		
Ionized Ca++		**GBS ds**		**RVD**	**+**	**-**
***Mg ++**		**pO2**		**HBV**	**+**	**-**
Other		**FIO2**		**HCV**	**+**	**-**

***Compulsory Blood Tests**
Potassium, Calcium and Magnesium levels: may be reduced by the apheresis procedure.
Haemoglobin level: required for all apheresis procedures.
Haematocrit and Leucocyte count: required to establish the interface on the day of the procedure.
These tests are ideally performed on the day of/ day prior to the procedure and cannot be older than 72 hours.

Study Participant Details		DOB/ ID Number	

Medication on first day of procedure			
Medication	Dosage	Route	Frequency

1. Please notify the Apheresis Staff if the procedure is cancelled or the study participant's condition changes.
2. Please note completion of the necessary documentation is a medico-legal requirement and any delays in the completion of the paperwork will result in delays in the procedures.

CHECKLIST	
Study Participant details	Weight (daily for the duration of procedures).
Documents	Completion of a consent form.
	Completion of a request form
Ward/ cubicle	Working light source
	Working water supply
	Working electricity supply
	Working suction supply
Central venous catheter (CVC)	If subclavian or internal jugular veins, CXR confirmation of the position of CVC and exclusion of pneumothorax. ***NOTE: It is the attending physician's responsibility to ensure the correct placement of the central venous catheter.***
Blood results: Daily	FBC.
	Calcium.
	Magnesium
	U&E and creatinine

STANDING ORDERS FOR EMERGENCY TREATMENT OF ADVERSE EFFECTS DURING LEUKAPHERESIS

Standing orders for the treatment or prevention of adverse effects during a Leukapheresis are reviewed by the Apheresis Director. The Apheresis Staff and/or the Apheresis Director and the attending physician must be notified, as soon as possible, of any adverse reaction that occurred after the procedure.

1. Citrate toxicity or hypocalcaemia

b) Study participants that have Leukapheresis performed should have ionized calcium or a total and corrected calcium level tested.

c) In a study participant presenting with an ionised calcium level less than 1 mmol/L or a corrected calcium count less than 2 mmol/L, intravenous calcium should be administered (e.g. administer 1 ampoule calcium gluconate IV over three minutes and administer 1 ampoule calcium gluconate 10% in a 200ml saline over 2-3 hours during the procedure).

d) A study participant presenting with an ionised calcium count of 1.1 mmol/L or corrected calcium count of less than 2.15 mmol/L, administer 1 ampoule calcium gluconate in a 200ml saline over 2-3 hours during the procedure.

e) If a study participant presents with symptoms of mild hypocalcaemia, administer 1 gram of oral calcium gluconate (e.g. Calcium Sandoz). The dose can be repeated PRN x2.

f) If a study participant develops moderate to severe hypocalcaemia, administer 1 ampoule of calcium gluconate 10% in a 50ml saline solution over 10 minutes. Alternatively, administer calcium by slow intravenous (IV) push.

Agreement by attending physician designate
I have medically examined the study participant and undertaken the relevant laboratory investigations and I consider the study participant will tolerate the procedure without any significant untoward reaction.
I permit the SANBS Registered Nurses to swap the draw and return lines of the central venous catheter if necessary, to obtain adequate flow rates during the apheresis procedure.

I understand that the technical procedure is being undertaken by the staff of SANBS. I have made arrangements for emergency medical care should it be necessary. I authorise the administration of medication routinely used during this type of procedure. I understand that I as the attending physician/designate primarily remain responsible for the medical management of the study participant and must be available for consultation during the leukapheresis, or in the event of any untoward reaction.

Any medical waste generated from the clinical apheresis procedure will be managed according to the clinical facility waste management guidelines.

_____ _____

Name of Responsible Physician/Designate **Signature**

_____ _____

Practice Number **Contact Number**

_____

Date