FRM5121/2 - Therapeutic Apheresis Service - Request for Therapeutic Apheresis

NHS Blood and Transplant

Effective date: 18/11/2024

Patient Demographics

Last Name	First Name(s)	
NHS Number	Hospital Number	
D.O.B	Sex assigned at birth	Patient contact Number
Hospital	Ward /Outpatient	Ward Contact Number
Consultant Name	Consultant Contact Number	

What type of procedure is required?
What is the diagnosis of the patient's illness?
What is the indication for apheresis?
What is the target of apheresis?
How will the effectiveness of apheresis be measured?

Procedure Information

Number of apheresis procedures requested:	
Over what time period:	
Preferred date of first procedure:	
Is this treatment part of research or a trial?	

Is the patient suitable for treatment on the apheresis unit?	Yes ☐	No ☐
If no, where will the procedures take place?		
Height	Weight	

Replacement Fluids

Do you authorise NHSBT to manage patient fluids?	Yes ☐	No ☐
Human Albumin Solution (4.5% - 5%) and saline are standard replacement fluid except for TTP when Octaplas is used. Does this patient require different fluids?	Yes ☐	No ☐
If yes, please specify:		

Does the patient have any signification medical illness which would affect apheresis (significant cardiovascular, clotting or allergies)?

Please provide relevant blood test / laboratory results

Medication:

Vascular Access

Are peripheral veins adequate for apheresis? Yes ☐ No ☐
Is an **apheresis** central line already in place? Yes ☐ No ☐
Will an **apheresis** central line be inserted? Yes ☐ No ☐
(If yes, please advise date of insertion)

Risk Assessment

Transfusion Associated Circulatory Overload risk assessment completed? Yes ☐ No ☐ N/A ☐	
Bleeding risk? Yes ☐ No ☐ e.g. recent/planned biopsy, medication, active bleeding	Details
Infection risk? Yes ☐ No ☐	Details

Detail of member of staff completing this form

Name:		Grade:	
Date:		Signature:	
Phone Number		Email address:	

(*To ensure confidentiality please ensure an nhs.net email address is provided)