

**MEDICAL UNIVERSITY OF SOUTH CAROLINA
HEMAPHERESIS UNIT
CHARLESTON, SC 29425
EXPLANATION AND CONSENT FOR THERAPEUTIC PLASMA EXCHANGE**

I. This procedure has been explained to me by _____ in a language I understand.
The following is a summary of plasmapheresis:

DEFINITION:

Therapeutic plasma exchange is the separation of plasma from whole blood. Plasma is the liquid portion of blood. It contains proteins, antibodies and coagulation (clotting) factors.

PURPOSE:

To remove the plasma portion of my blood to correct the symptoms or side effects involved in my disease.

PROCEDURE AND SIDE EFFECTS / RISKS:

A. A blood cell separator will be used to centrifuge (spin) my blood to separate the plasma from the whole blood. Once separated, my plasma will go to a waste bag and my red blood cells, white blood cells and platelets will be returned to me along with a replacement fluid. The replacement fluid will be human plasma from the blood bank or a plasma substitute as ordered by the hemapheresis physician.

B. My blood will be removed from me and returned to me by using one needle in each arm or if my veins are not large enough by a central line venous catheter. If a central line venous catheter is used, it will be placed by a licensed physician (doctor).

C. While my blood is in the cell separator, it will be mixed with a medication to keep it from clotting. There are some side effects and risks involved in having this procedure done which may include feeling lightheaded, tingling of the mouth, hands or feet, dryness of the lips, chills, lowered blood pressure, and rarely nausea, vomiting, fainting, or irregular heart beats. Also bruising from the needles or catheter placement, infection, blood loss, and very rarely air bubbles in the blood stream may occur.

II. I, _____, agree to have therapeutic plasma exchange (or exchanges) performed on _____ by the Hemapheresis staff (under the direction of the Hemapheresis attending doctor) according to my doctor's recommendation to help decrease the symptoms of my disease. I give the Hemapheresis doctor, his/her designated persons or his/her assistants permission to perform any therapy or procedure that may become necessary in the doctor's judgement as a result of any side effects or risks from the performance of this procedure. There have been no guarantees made to me as a result of this treatment. I am willing to participate in this treatment according to my own will.

I understand that neither the Medical University of South Carolina nor the Hemapheresis Unit will be responsible for payment of any costs for any treatment, procedures or therapies I may require associated with any condition, injury, or reaction resulting from this procedure.

_____/_____
Signature of Patient/Guardian Date Relationship to Patient

Phone Consent from: _____ Obtained by: _____ / _____
Date

_____/_____
Witness Signature Date

III. I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, alternatives available and expected results as directed above.

Physician obtaining consent