MEDICAL UNIVERSITY OF SOUTH CAROLINA
HEMAPHERESIS UNIT
CHARLESTON, SC 29425

EXPLANATION AND CONSENT FOR ERYTHROCYTOPHERESIS (RED CELL EXCHANGE)

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

DEFINITION:
Erythrocytopheresis (red cell exchange) is the separation of red blood cells from the whole blood.

PURPOSE:
To remove and replace the red blood cells which are involved in my disease process and decrease my risk of complications associated with my disease.

PROCEDURE AND SIDE EFFECTS / RISKS:
A. A blood cell separator will be used to centrifuge (spin) my blood to separate the red cells from the whole blood. Once separated, my red cells will go to a waste bag and my plasma, white blood cells and platelets will be returned to me along with red blood cells from the blood bank. The removal and replacement of red blood cells will be done at the same rate of speed.

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. These may include lightheadedness, tingling of the mouth, hands or feet, dryness of the lips, chills, and rarely nausea, vomiting, fainting, irregular heartbeats, and lowered blood pressure. Also bruising from the needle or catheter placement, infection, lowered protein levels, blood loss, and very rarely air bubbles in the blood stream may occur.

II. I, _____, agree for erythrocytopheresis (red cell exchange) to be 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.

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

Phone Consent from: _____ Obtained by:_____/_____

_____/_____
Witness Signature Date

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

_____
Physician obtaining consent