HEMAPHERESIS
Red Cell Exchange
Treatment Plan

Department of Pathology and Laboratory Medicine
Hemapheresis Unit
MUSC Medical Center
171 Ashley Avenue
Charleston, SC 29425

Date: Location:

Med. Record #

Patient Name:

Race: Sex: DOB

Date:

Perform one volume / partial red blood cell exchange replacing with units of washed or leukocyte reduced packed red blood cells and ACD A anticoagulant.

Medications: ____

Labs: ____

Physician Name (Please Print) Physician Signature

Consult written: Yes No

The consent form and additional information for this hemapheresis procedure are maintained in the Hemapheresis Unit, room EH 201 Children's Hospital, phone 792-4389

(Prepared: 10/01)