HEMAPHERESIS
Therapeutic Plasma 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 plasma exchange using replacement and ACD A / B anticoagulant.

Supplement with:

_____ Calcium gluconate 1.86 mEq per 500 ml replacement

_____ KCL 2.5 mEq per 500 ml replacement

_____ Other

Labs: ___

Additional Orders: ___

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)