Therapeutic Apheresis Collection Physician's Order Form: F.CTC.7802E

Form must be completed in blue or black ink

Patient/Donor Name:	GHS ID#: NMDP ID#:	Sex: Male ☐ Female ☐	Date of Birth:	Donation type: Autologous ☐ Allogeneic ☐ NMDP ☐	Ordering Physician:

(Items with a ☒ are active orders, orders with a ☐ must be checked to be an active order)

Section I: Physician Information

Attending / Ordering Physician: _____

Physician Office Phone #: _____Fax: _____

Physician office address: _____

Contact Nurse Name: _____Nurse Phone #: _____

Section II: Patient information

Date Ordered: _____ Time: _____

Height: _____ft. _____in. Weight: _____ lbs.

Primary Diagnosis: _____

Allergies: _____

Section III: Physician Orders / Collection Information

Mobilization Regimen: _____ Regimen Start Date: _____

Date Infectious Disease Panel Drawn: _____ Anticipated Collection Start Date: _____

Anticipated High Dose Therapy Start Date: _____ Anticipated Reinfusion Date: _____

General

☒ Complete patient pre-assessment prior to initiating the collection, form: *F.CTC.7902A*

☒ Obtain appropriate consent for the series of leukapheresis ordered for PBSC harvest prior to initiation the collection

☐ **For Auto/non-NMDP Allo donors**: Daily leukapheresis, not to exceed 4 days. May process up to 24L/1 day with adequate peripheral CD34 or as directed by the transplant physician.

☐ **For NMDP donors**: Daily leukapheresis (not to exceed 2 days). May process up to 24L. Do not exceed 24L/2 day collect in total. Apheresis procedure to begin at least 1 hour after Filgrastim injection given on day 5 only.

☒ Continue collection until and end point is reached within 10% of endpoint

Endpoint:

☐ > $3.0x10_6$ **OR**

☐ > $6.0x10_6$ **AND**

☐Greater than or equal to_____

☐ Total Mononuclear Cell Target _____ x 10^7/kg Minimum _____liters processed

☒ Perform CVC pre and post care per SOP

☒ Flush each lumen of each apheresis CVC with 10ml of Normal Saline and leave TEGO™ caps in place after procedure

☒ Arrange with GHS staff for removal of temporary CVC if platelet count greater than or equal to 50K and endpoint Is reached

☒ Discharge patient when stable

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Lab

CMV Status: ☐Positive ☐Negative

Pre-leukapheresis (every collection): ☒CBC W/ Diff ☒CMP ☒Magnesium ☒Peripheral CD34+

TC Specimen Requirement:

Day 1: ☐Red Top_____ ☐Purple (EDTA)_____ ☐Yellow Top_____☐Green Top _____

Day 2: ☐Red Top_____ ☐Purple (EDTA)_____ ☐Yellow Top_____☐Green Top _____

Pre-leukapheresis: (day #1 only): ☒Blood type, ABO/Rh ☐NMDP Lab Kit

☐Infectious Disease Panel (if not done within the last 30 days) ☐Auto ☐Allo

Post-leukapheresis (every collection): ☒ CBC W/ Diff

☒Arrange for transfusion needs with staff according to guidelines below:

Platelet Guidelines:

For platelet counts <20,000 Pre-Collection ~Give 1 unit of Single Donor Pheresis Platelets (SDPP) prior to collection

For platelet counts <20,000 Post-Collection~Give 1 unit of Single Donor Pheresis Platelets (SDPP) post collection

For platelet counts 20,000-30,000 ~Give 1 unit of Single Donor Pheresis Platelets (SDPP) after collection

RBC Guidelines:

For Hgb ≤7.5 ~Type and cross match for 1 units and give AFTER procedure

For Hgb <7.5 ~Type and cross match for 1 units and give BEFORE procedure

Other Medication Orders

☒Calcium Gluconate 2.5 grams IV in 250ML of NaCl to be infused throughout the procedure. Start at 50ml/hr and titrate to treat any symptoms of citrate toxicity. May repeat x1

☒Ativan 1mg IVP every 4 hours as needed for nausea, vomiting, anxiety, and/or restlessness

☒Tylenol 650mg PO every 4 hours as needed for pain

☒Administer lidocaine intradermally, as needed, at site of IV access prior to peripheral insertion per Greenville Health System policy.

Other Orders

☒Report patient symptoms or abnormal labs (e.g. K+, Mg+) to GHS clinical staff for management as needed.

☐_____

☐_____

Section IV: Physician Signatures

Telephone orders must be read back and confirmed

This signature certifies that I am a licensed South Carolina physician and have requested leukapheresis be performed on the above named patient. The indication for this procedure is for collection, processing, and storage of stem cells for rescue therapy after high dose chemotherapy.

Physician's Signature: _____ Physician's Printed Name: _____

Date: _____

Section V: TBC Information and Signatures

Comments: _____

Medical approval by: _____ Date: _____
Medical Director/Designee Signature

RN Signature/Tech code: _____ Date: _____

Reviewed by: _____ Date:_____
Department Manager or Designee