



ATTENDING PHYSICIAN'S REQUEST FOR THERAPEUTIC APHERESIS

Procedure Requested _____ Requested Start Date: _____

Frequency/Duration: _____

Quantity of Component to be Removed per Procedure: _____

Replacement Fluid Requested: _____

Vascular Access: _____

PATIENT INFORMATION

Name: _____ Facility: _____ Room # _____

Age: _____ Sex: _____ Height: _____ Weight: _____ HCT: _____

DIAGNOSIS: _____

MEDICAL HISTORY: _____

MEDICATIONS: _____

The procedure has been explained to the patient and verbal consent has been obtained. The patient has been sufficiently hydrated to tolerate the procedure.

Physician's Signature: _____ Date: _____

Name (Please Print): _____ Phone Number: _____

UBS USE ONLY

Date/Time Request Received: _____ Received By: _____

Assigned Staff: _____

Date/Time Referred to Medical Director: _____

United Blood Services Medical Director's Approval:

Medical Director Comments: _____

Signature: _____ Date: _____