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SPARROW HEALTH SYSTEM
Lansing, Michigan

Apheresis Orders

Name _____

ATTENTION PHYSICIANS: **Please indicate dose, route and frequency of each medication ordered. Medications are discontinued per hospital policy unless otherwise specified.**

Date _____ Time _____

ORDERS

1. Acuity level:
2. Admit to:
3. Diagnosis:
4. History & Physical attached
5. Procedure (check one):
   - ☐ Plasmapheresis
   - ☐ Red Cell Exchange
   - ☐ Apheresis Cell Depletion
     - a) Indicate replacement solution (if applicable)
       - ☐ 5% Albumin
       - ☐ F.F.P.
       - ☐ Other _____
     - b) Indicate fluid balance
       - ☐ Standard is 100% of calculated volume
       - ☐ Other _____
6. Diet:
7. Activity:
8. Vital signs every ____hours
9. Labs:
   - ☐ Initial therapeutic procedure-draw CBC & Fibrinogen pre-apheresis
     -draw Fibrinogen post-apheresis
   - ☐ Successive therapeutic procedure
     -draw PBC & Fibrinogen pre-apheresis
     -draw Fibrinogen post-apheresis
   - ☐ UCG if childbearing age
10. Medications:
11. Start IV with _____@ _____ml/hr.
12. PRN meds:
    diphenhydramine (Benadryl®) 25-50mg (PO/IV) every 4 hrs., PRN, reaction
    acetaminophen (Tylenol®) 650 mg (PO) every 4 hrs., PRN, pain/fever
    methylprednisolone (SoluMedrol®) _____mg (IVP) times 1, PRN, reaction
13. Additional orders:
14. Discontinue IV at discharge
15. May discharge to home _____hours after procedure, if criteria met and no problems develop.
16. Follow-up with Dr.:

Authorization is granted to supply by non-proprietary name as per formulary policy unless checked here. ☐

Doctor **X**	**Reg. No.**	
Verbal/Telephone orders read back ☐ **yes**	**Date**	**Time**
Noted By **X** **R.N.**	**Date**	**Time**