

Form 1

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Informed Consent for Haemapheresis Therapy

Name:	First name:	Date of birth:
Address:		ID-No.:

I was informed about the need of an haemapheresis therapy. I was extensively informed from _____ about the type, purpose and way of the treatment, its advantages and disadvantages as well as risks also in comparison to other methods of treatment to the rejection.

My attention is also being drawn to possible physical complications during the time and after the treatment. Special problems have extensively been described to me. Mainly: drop of blood pressure, irritation and information of punctured veins, and infection, especially HIV, Hepatitis and other viral diseases, if blood or blood components such as plasma have to be applied. Such infections do not occur if secondary plasma separation technologies are applied. Citrate intolerance (recognised from paraesthesia in the finger tips, toes and mouth, muscle cramps and irregularities of the heart beat), haemolysis, air embolism, thrombus formation and intolerance of protein (shaking skills, increase of temperature).

In spite of all appropriate care it can not completely excluded that a treatment cannot be finished and that the blood outside of the organism cannot be returned. May questions were completely answered. I wish / do not wish further information on specific details of the treatment.

I know that this informed consent may be revoked at any time.

I agree with the suggested physical treatment – haemapheresis treatment – including the appropriate extensions and alterations and the necessary measures to prevent any kind of damage for my health.

I ensure, that all diseases and complaints of my history were mentioned to the examining physician. I was informed about the appropriate treatment before and following the therapy, especially that

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Location, Date

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Patient

.....
Physician

Form 2

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Haemapheresis treatment – Risk factors

Name:	First name:	Date of birth:	ID-No.
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<u>PULMO-KARDIOLOGICAL DISEASES</u>	Yes	No	Remarks
Cardiac insufficiency	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiac arrhythmia	<input type="checkbox"/>	<input type="checkbox"/>	_____
History of myocardial infarction	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypertonie	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypotonie	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory insufficiency, Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
History of pulmonary oedema	<input type="checkbox"/>	<input type="checkbox"/>	_____
History of tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
History of artificial respiration	<input type="checkbox"/>	<input type="checkbox"/>	_____

<u>GASTROINTESTINAL DISEASE</u>			
Ulcus ventriculi / duodeni	<input type="checkbox"/>	<input type="checkbox"/>	_____

<u>UROGENICAL DISEASE</u>			
Compromised kidney function	<input type="checkbox"/>	<input type="checkbox"/>	_____

<u>ENDOKRINE DISEASES</u>			
Diabetes mellitus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diseases of the thyroidea	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diseases of the parathyroid glands	<input type="checkbox"/>	<input type="checkbox"/>	_____

<u>LEVER DISEASES</u>			
History of hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____

<u>DISEASES OF THE CENTRAL NERVOUS SYSTEM</u>			
Epilepsia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brain vessel sclerosis / apoplexia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Transemic ischemic attacks	<input type="checkbox"/>	<input type="checkbox"/>	_____
Compromised consciousness	<input type="checkbox"/>	<input type="checkbox"/>	_____

<u>DISEASES OF THE BLOOD AND KOAGULTION SYSTEM</u>			
Anaemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thromboses	<input type="checkbox"/>	<input type="checkbox"/>	_____
Embolism	<input type="checkbox"/>	<input type="checkbox"/>	_____

<u>INFECTIOUS DISEASES</u>	<input type="checkbox"/>	<input type="checkbox"/>	_____
	<input type="checkbox"/>	<input type="checkbox"/>	_____

<u>DISEASES OF THE IMMUNSYSTEM</u>			
Immunosuppression	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergic diseases	<input type="checkbox"/>	<input type="checkbox"/>	_____

<u>PREGNANCY</u>	<input type="checkbox"/>	<input type="checkbox"/>	_____
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<u>MEDICATIONS</u>					
Immunosuppressant	<input type="checkbox"/> none	<input type="checkbox"/> Glucocorticoids	<input type="checkbox"/> Azathioprin	<input type="checkbox"/> Cyclophosphamid	
Anticoagulans	<input type="checkbox"/> none	<input type="checkbox"/> Heparin	<input type="checkbox"/> Cumarine	<input type="checkbox"/> ASS	
Digitalis	<input type="checkbox"/> none	<input type="checkbox"/> Digoxin	<input type="checkbox"/> Digitoxin		
Antiarrhythmic drugs	<input type="checkbox"/> none	<input type="checkbox"/> CSA			
Antidiabetic drugs	<input type="checkbox"/> none	<input type="checkbox"/> oral	<input type="checkbox"/> Insulin		
ACE-Inhabitators	<input type="checkbox"/> none				
Others					

Patients signature

Date

Physicians signature

Form 3 a

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Haemapheresis Treatment - Test

Name:		First name:	Date of birth:
Street / No.:			ID-No.:
Zip	Address:		Tel.:
Health insurance:	Hospital:	Board:	
Treating physician:			

DIAGNOSIS:

Weight: _____ kg Size: _____ cm Blood volume _____ ml
 Plasma volume _____ ml

BLOOD GROUP

Laboratory tests (not older than 2 weeks prior to the treatment)

1. ECG
2. X - ray - thorax*)
3. Infections
 HB_sAg HCV-AK HIV 1/2-AK Lues (TPHA)
4. Blood count
 Ery _____ 10⁶/μl Leuco _____ 10³/μl Platelets _____ 10³/μl
 Hb _____ g/dl HKT
5. Liver enzymes GOT _____ GPT _____ γGT _____ LDH _____ _____ U/l
6. Electrolytes Na _____ K _____ Ca _____ Cl _____ _____ mmol/l
7. Urea _____ mg/dl Creatinin _____ mg/dl
8. Glucose _____ mg/dl
9. Total protein _____ g/l Albumin _____ g/l IgG _____ IgM _____ IgG _____ g/l
10. Coagulation
 Quick _____ % PTT _____ s Fibrinogen _____ mg/dl AT III _____ %

Date _____ Signature _____

*) Only if requested due to specific history

Form 3 b

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Haemapheresis Therapy: - Subsequent Treatment (cycle) No. _____

Name:	First name:	Date of birth::	ID No.
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Changes since the last treatment (History – diseases?)

Allergy? Yes / No _____
Pregnancy? Yes / No _____

DRUGS

Immunosuppressive none Glucocorticoids Azathioprine Cyclophosphamide
 Anticoagulants none Heparin Cumarin ASS _____
 Digitalis none Digoxin Digitoxin
 Antiarrhythmics none
 Antidiabetics none oral Insulin
 ACE-Inhibitors none
 Other _____

LABORATORY TEST

Blood count

Ery _____ $10^6/\mu\text{l}$ Leuco _____ $10^3/\mu\text{l}$ Thrombo _____ $10^3/\mu\text{l}$

Hb _____g/dl HKT _____%

Liver enzymes GOT _____ GPT _____ γ GT _____ LDH _____ _____ U/l

Electrolytes Na _____ K _____ Ca _____ Cl _____ _____ mmol/l

Urea _____mg/dl Creatinin _____mg/dl

Glucose _____mg/dl _____

Total protein _____g/l Albumin _____g/l IgG _____ IgM _____ IgG _____g/l

Coagulation

Quick _____% PTT _____s Fibrinogen _____mg/dl AT III _____%

Serology of infections

HB_sAg _____ HCV-AK _____ HIV 1/2-AK _____ Lues (TPHA) _____

ECG _____

Date _____

Signature _____