

**Form 4b**

Version: 01 since: page:		Number:	
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***Leukocytapheresis Treatment – Treatment Protocol – I***

Name:	First name:	Date of birth:	ID-No.
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Treatment cycle \_\_\_\_\_ No. \_\_\_\_\_ Date \_\_\_\_\_

Type of treatment \_\_\_\_\_ Device (technique) \_\_\_\_\_ Set/Charge \_\_\_\_\_

Blood-/plasma volume to be processed \_\_\_\_\_ Program \_\_\_\_\_

Exchange fluid/differential separation system \_\_\_\_\_

Access to the circulation \_\_\_\_\_

**SAFETY CHECK PRIOR TO THE TREATMENT**

- Priming complete and bubble free ( )
- Return line completely filled ( )
- NaCl-clamp (priming) closed ( )
- Alarms in complete function ( )
- Primary system and needles safely connected ( )
- Sekundary system o.k. ( )
- Infusion pumps without problems ( )
- All solutions transparent and clear ( )
- All solutions correctly connected Citrate ( )  
NaCL ( )

- AC/whole blood ratio
- Program
- Blood warmer (temperature)
- Batch documentation (Set, solution ..... ) ( )  
( )

**CONTROLS DURING THE TREATMENT**

	Time					
Return without problems (waste)						
Exchange fluid returned to patient						
AC-whole blood ratio 1 : _____						
Heparin - infusion _____ IU/h						
Separated plasma transparent and clear						
Collection bag continuously filled						
Aggregation?						
Pump speed (ml/min)						
Plasma						
Erythrozytes						
Antikoagulaion						
Infusion						

Problems/Remarks \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Prepared: \_\_\_\_\_ Signature: \_\_\_\_\_

Controlled: \_\_\_\_\_ Signature: \_\_\_\_\_

**Form 5b**

Version: 01 since: page:	Name: First name: Date of birth:	Number.	
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***Leukocytapheresis Treatment – Treatment Protocol - II***

**Infusions / Transfusions**

	Type	Blood group	Manufacturer	Batch	Volume (ml)	Cross matching
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

Exchange – Total volume (ml) \_\_\_\_\_

<u>Other Infusions</u>		<u>Product</u>	<u>Collection bag</u>
ACD A	ml _____ Ch. _____ Heparin _____	Total weight (g)	_____
Citrate (%)	ml _____ Ch. _____ Ch _____	Net weight (g)	_____
NaCl (0,9%)	ml _____ Ch. _____ before _____ IU	Net volume (ml)	_____
Electrolytes	ml _____ during _____ IU	Leuco x 10 <sup>9</sup> /l	_____
	ml _____ total _____ IU	Ery x 10 <sup>12</sup> /l	_____
Total-volume:	ml _____	HK %	_____
		Platelets x 10 <sup>9</sup> /	_____
		MNC x 10 <sup>10</sup>	_____
Patient weight	before _____ kg	Leukocytes x 10 <sup>10</sup>	_____
	after _____ kg	Erythrocytes ml	_____
		Platelets x 10 <sup>11</sup>	_____
		MNC x 10 <sup>10</sup>	_____

START OF TREATMENT: \_\_\_\_\_ TIME - END \_\_\_\_\_ Time - PERIOD \_\_\_\_\_

P	RR											hours
200	300											
190	280											
180	260											
170	240											
160	220											
150	200											
140	180											
130	160											
120	140											
110	120											
100	100											
90	80											
80	60											
70	40											
60	20											
50												
40												

Side effects: No / Yes (s. appendix III)  
 UV-irradiation: System (device) \_\_\_\_\_ Energy \_\_\_\_\_ (Joule/Min)  
 Bag (manufacturer) \_\_\_\_\_ Time period: \_\_\_\_\_ (Min)  
 Remarks: \_\_\_\_\_  
 Operator \_\_\_\_\_ Physician \_\_\_\_\_ Date \_\_\_\_\_

**Form 6b**

Version: 01 since: pagee:		Number:.	
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***Leukocytapheresis Treatment – Treatment Protocol - III***

Name:	First name:	Date of birth:	ID-No.
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Treatment cycle \_\_\_\_\_ No. \_\_\_\_\_ Date \_\_\_\_\_

Technical problems:

1. Automated control
2. Safety system
3. Mechanics
4. Currency
5. Separation chamber
6. Tubing set
7. Coagulation
8. Haemolysis
9. Separation problems (irregularities)
10. Termination (reason?)
11. Other problems

Remarks (explanations): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient problems during the separation:

Subjective complaints:

1. Headache
2. Sweating
3. Vertigo
4. Heart beat
5. Vomiting
6. Local paraesthesia (e.g. tongue)
7. Generalised paraesthesia
8. Other problems

objective complaints:

1. Tetany
2. Arrhythmia (ECG)
3. Vomiting
4. Blood flow
5. Drop of blood pressure (more than 30 mmHg)
6. Puls (irregularities, increase of more than 30 per min.)
7. Temporary interruption (explanation requested)
8. Temination (explanation requested)
9. Other problems

Explanation: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Operator \_\_\_\_\_ Signature \_\_\_\_\_

Physician \_\_\_\_\_ Signature \_\_\_\_\_