

**Form 7**

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**Informed Consent for Plasma Exchange Therapy**

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

I was informed that an extracorporeal therapy named plasma exchange is a necessary therapy for me. Type, purpose and performance of the therapy, the advantages and disadvantages or risks respectively also in comparison to other treatments and the consequences of omitting the treatment were explained to me from

\_\_\_\_\_

The potential physical complications during the time and after the treatment were discussed with me. Special problems have extensively been mentioned especially hypotonia, venous problems and inflammations, haematoma, infection (AIDS, hepatitis, if blood and blood components - plasma – are given. Citrate intolerance (paraesthesia at the finger tips, toes and lips, muscle cramps, irregularities of heart beat), lysis of blood cells (haemolysis), air embolism, coagulation, incompatibilities against unrelated protein (shaking chill, increase of body temperature).

In spite of all precautions it may - though extremely rare – occur that due to technical complications the treatment cannot be finished and the blood within the technical system cannot be return to me. My question were completely answered. I do not want to be informed on further details, however, I am informed that any further questions will be answered to me.

I am informed that this consent can be rejected any time.

I declare, that I agree with the suggested therapy - plasma exchange - as well as with modifications and changes necessary to prevent any physical damage to me.

I assure that all diseases and symptoms known to me were completely mentioned in my history. I was informed about the appropriate behaviour prior to and following the treatment especially on

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.....  
.....

Location, Date

.....  
Patient

.....  
Physician

## Form 8

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### *Plasma Exchange Therapy – Diagnosis of Risk Factors*

Name:	First name:	Date of birth:	ID-No.
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<u>PNEUMO-CARDIAC DISEASES</u>	Yes	No	Remarks
Myocardial insufficiency	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arrhythmia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Myocardial infarction	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypotonia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory insufficiency	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pulmonary oedema	<input type="checkbox"/>	<input type="checkbox"/>	_____
TBC	<input type="checkbox"/>	<input type="checkbox"/>	_____
Artificial respiration	<input type="checkbox"/>	<input type="checkbox"/>	_____
 <u>GASTROINTESTINAL DISEASES</u>			
Ulcus ventriculi / duodeni	<input type="checkbox"/>	<input type="checkbox"/>	_____
 <u>UROGENITAL DISEASES</u>			
Compromised kidney function	<input type="checkbox"/>	<input type="checkbox"/>	_____
 <u>ENDOCRINE DISEASES</u>			
Diabetes mellitus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroidal diseases	<input type="checkbox"/>	<input type="checkbox"/>	_____
Parathyroidal diseases	<input type="checkbox"/>	<input type="checkbox"/>	_____
 <u>LIVER DISEASES</u>			
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
 <u>DISEASES OF THE CENTRAL NERVOUS SYSTEM</u>			
Epilepsia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cerebral sclerosis / Transitory ischaemic attack /apoplexia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Compromised consciousness	<input type="checkbox"/>	<input type="checkbox"/>	_____
 <u>DISEASES OF THE BLOOD AND COAGULATION SYSTEM</u>			
Anaemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding tendency	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thrombophilia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Risk of embolism	<input type="checkbox"/>	<input type="checkbox"/>	_____
 <u>INFECTIOUS DISEASES</u>			
<input type="checkbox"/>	<input type="checkbox"/>		_____
 <u>DISEASES OF THE IMMUNSYSTEM</u>			
Frequent infections	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergic diseases	<input type="checkbox"/>	<input type="checkbox"/>	_____
 <u>PREGNANCY</u>			
<input type="checkbox"/>	<input type="checkbox"/>		_____
 <u>DRUGS</u>			
Immunosuppressive agents <input type="checkbox"/> none	<input type="checkbox"/> Glucocorticoids	<input type="checkbox"/> Azathioprin	<input type="checkbox"/> Cyclophosphamide
Anticoagulants <input type="checkbox"/> none	<input type="checkbox"/> Heparin	<input type="checkbox"/> Cumarin	<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		
Antidiabetics <input type="checkbox"/> none	<input type="checkbox"/> oral	<input type="checkbox"/> Insulin	
ACE-inhibitors <input type="checkbox"/> none			
Others			

\_\_\_\_\_  
Physician

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

**Form 9a**

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***Plasma Exchange Therapy – Laboratory and other Examinations***

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<sub>s</sub>Ag      HCV-AK      HIV 1/2-AK      Lues (TPHA)
4. Blood count  
Ery \_\_\_\_\_ 10<sup>6</sup>/μl      Leuco \_\_\_\_\_ 10<sup>3</sup>/μl      Platelets \_\_\_\_\_ 10<sup>3</sup>/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 9b**

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**Plasma Exchange Therapy: Subsequent Treatment (cycle) No. \_\_\_\_\_**

Name:	First name:	Date of birth:	ID-No.
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Changes following the first / last treatment (history / diseases?)

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Allergy? Yes / No      Against? \_\_\_\_\_

Pregnancy? Yes / No

Medication

Immunosuppression     none             Glucocorticoids             Azathioprine             Cyclophosphamide  
 Anticoagulants         none             Heparin             Cumarin             ASS             \_\_\_\_\_  
 Digitalis                 none             Digoxin             Digitoxin  
 Antiarrhythmics       none  
 Antidiabetics          none             oral             Insulin  
 ACE-Inhibitors         none  
 Other

LABORATORY DATA

Blood count

Ery \_\_\_\_\_  $10^6/\mu\text{l}$       Leuco \_\_\_\_\_  $10^3/\mu\text{l}$       Platelets \_\_\_\_\_  $10^3/\mu\text{l}$

Hb \_\_\_\_\_ g/dl      HKT \_\_\_\_\_ %

Liver enzymes    GOT \_\_\_\_\_ U/l    GPT \_\_\_\_\_ U/l     $\gamma$ GT \_\_\_\_\_ U/l    LDH \_\_\_\_\_ U/l

Electrolytes    Na \_\_\_\_\_ mmol/l    K \_\_\_\_\_ mmol/l    Ca \_\_\_\_\_ mmol/l    Cl \_\_\_\_\_ mmol/l

Urea \_\_\_\_\_ mg/dl    Creatinine \_\_\_\_\_ mg/dl

Glucose \_\_\_\_\_ mg/dl

Total protein \_\_\_\_\_ g/l    Albumin \_\_\_\_\_ g/l    IgG \_\_\_\_\_ g/l    IgM \_\_\_\_\_ g/l    IgG \_\_\_\_\_ g/l

Coagulation

Quick \_\_\_\_\_ %    PTT \_\_\_\_\_ s    Fibrinogen \_\_\_\_\_ mg/dl    AT III \_\_\_\_\_ %

Serology

HB<sub>s</sub>Ag \_\_\_\_\_    HCV-Ab \_\_\_\_\_    HIV 1/2-Ab \_\_\_\_\_ Lues (TPHA) \_\_\_\_\_

ECG \_\_\_\_\_

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