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## Authorization for Therapeutic Plasma Exchange (TPE)

I, \_\_\_\_\_ have been informed that I am in need of  
(Patient's name)  
therapeutic plasma exchange (TPE).

The procedure necessary to treat my condition has been explained to me by my physician, and I understand the nature of the procedure to be as follows:

TPE is an extracorporeal (ie outside the body) blood purification technique designed to remove large molecules from the blood. Examples of these substances include antibodies, immune complexes, cholesterol-containing proteins, and certain toxins (endotoxin).

I understand that this treatment will require the administration of an anticoagulant as well as appropriate replacement fluids, which may include human-derived blood products as an essential part of this treatment.

I understand that TPE involves, among other things, the insertion of tubes and/or needles into my veins or fistula or through a catheter and the use of a filter to remove plasma from my blood. I also understand that, along with the TPE treatment, I may need laboratory tests, radiology and surgical procedures to assure adequate function of the equipment and effectiveness of the treatment.

I have been informed that the following risks are associated with TPE and that while such risks are not common, one or more can occur and be potentially life threatening:

- Bacterial and/or viral (e.g., Hepatitis B or C) contamination of my blood which may cause infection, or bacterial infection of the blood called Sepsis;
- Bleeding due to blood clotting problems or disconnection of blood tubing;
- "Destruction" or the breakdown of red blood cells, known as hemolysis;
- Internal bleeding or bleeding from the access site;
- Infections of my access site (catheter or fistula infections);
- Introduction of air into my bloodstream;
- Clotting of my access or infiltration of my access.
- Shock, cardiac arrest, or death;
- Seizures
- Allergic and/or toxic reactions to drugs, solutions, or other equipment used during the TPE treatment.

\_\_\_\_\_ Patient Initial



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I have also been informed that there may be some side effects associated with TPE related to fluid and chemical changes during or after the treatment. Some of the side effects are tingling of lips/fingers, electrolyte imbalance, headache, nausea, vomiting, dizziness, fainting, irregular heartbeats, decrease in blood pressure, muscle cramping and mild confusion.

I am aware that, in addition to the reasonably foreseeable risks described, there are other foreseeable risks, which have been discussed with me, but are not listed. I affirm that I understand the purpose and potential benefits of the proposed treatment, that no guarantee has been made to me as to the results that may be obtained, and that an offer has been made to me to answer any of my questions about the proposed treatment.

The TPE procedure and the alternatives to TPE have been explained to me. I understand the alternatives to TPE vary depending on the condition being treated, and may include but are not limited to: steroid medication, immunosuppressive medication, chemotherapy, and possibly hemodialysis.

I will immediately notify the nursing staff and/or my physician of any adverse reactions or problems I may have with regard to these TPE treatments.

I authorize repeated TPE treatments, unless I specifically revoke this consent. This consent will be renewed on or about an annual basis.

This consent may be revocable by me at any time, except to the extent it has already been relied upon.

\_\_\_\_\_  
MD, APRN, PA

Signed: \_\_\_\_\_  
(Patient or legally authorized representative)

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Interpreter responsible for explaining procedures and special treatment:

\_\_\_\_\_ (Interpreter)

**PATIENT UNABLE TO SIGN PRIOR TO SURGERY [  ] BECAUSE:**

\_\_\_\_\_

\_\_\_\_\_ M.D. Date: \_\_\_\_\_ Time: \_\_\_\_\_

\_\_\_\_\_ Witness Date: \_\_\_\_\_ Time: \_\_\_\_\_