THERAPEUTIC APHERESIS CONSENT FORM

Surname:		First name/s:	
Address:		NHI No:	
		DOB:	
		Ward/Hospital:	

- I have already been informed that Apheresis has been recommended as a treatment for my condition, and I have given my consent for
  - □ Therapeutic Plasma Exchange
  - □ Red Blood Cell Exchange
  - □ Low-Density Lipoprotein Apheresis
  - □ White Blood Cell Depletion
  - □ Platelet Depletion
- I now consent to the procedure itself. This procedure and its risks have been explained to me and I have had the opportunity to read the procedure specific NZBS information sheet.
- I consent to 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 have had the opportunity to read the NZBS pamphlets entitled Fresh Blood Components and Intravenous Albumin Blood Products
- I consent to any further procedures that may be found necessary during the course of the therapeutic apheresis.
- If my peripheral veins are unable to be used, I understand that an appropriate intravenous catheter will be placed in my neck or other appropriate site to enable the procedure to be performed. Separate consent will be required for this procedure.

Signature:		Date:	

OR, ON BEHALF OF THE ABOVE PATIENT

(**Note** – Only the parent or guardian may sign below. The local hospital "Agreement to Treatment" guidelines should be used if neither is available and the patient is unable to give consent)

Full name:			
Address:			
Relationship to patient:			
Signature:		Date:	

I have read over and explained to the signatory, who stated that he/she understood the same and affixed his/her signature in my presence.

Full name:			
Designation:			
Signature:		Date:	