Bethesda Hospital East
2815 S. Seacrest Blvd
Boynton Beach, FL 33435
(561) 737-7733

Bethesda Hospital West
9655 Boynton Beach Blvd
Boynton Beach, FL 33472
(561) 336-7000

# CONSENT FOR THERAPEUTIC APHERESIS

PATIENT:

I authorize the performance of therapeutic apheresis on

of therapeutic apheresis to be performed by or under the direction of

Therapeutic Apheresis involves the separation, removal and replacement of specific blood cells or plasma components from my blood. This involves the passage of my blood from my circulatory system into a machine, where it is circulated through a device which acts to remove the specific blood cells or plasma components from the blood.

I have been made aware of certain risks, benefits or alternatives that may be associated with the procedure herein described. Possible risks are, but not limited to:

- The possibility of contamination of the blood with various bacteria or germs, which can result in bloodstream infection.
- The possibility of excess bleeding occurring within the body as a result of clotting problems of the blood, or externally due to disconnection of the bloodline.
- The possibility of contracting infections of the puncture site of catheter which allows access to the bloodstream.
- The potential hazard of air embolism forming in which air enters the machine and thereby gets into the patient's bloodstream, leading to severe complications, which may include death or paralysis.
- The possibility of irregular heartbeats, tingling or numbness of the fingers, chest, mouth or face, nausea, bruising at the site of needle insertion, or decrease in blood pressure resulting from certain chemical shifts within the patient's system.
- The possibility of a reaction to medications and/or replacement fluids given during the treatment which may result in adverse effects ranging from mild to (rarely) fatal shock or cardiac arrest.
- The possibility of excess fluid in the bloodstream, causing shortness of breath and/or changes in the heart rate and blood pressure.

☐ I acknowledge that no guarantee or assurance has been given to me by anyone as to the results that may be obtained.

☐ I acknowledge that all blank spaces on this document have been either completed or crossed off prior to my signing.

| | | | |
|---|---|---|---|
| Patient Name: | | Patient#: | |
| MR#: | | Attending physician: | |
| Admission Date: | | DOB: | |
| Gender: | | Age: | |

I acknowledge that I have read and understand the foregoing, and that I have asked and been afforded the opportunity to ask whatever questions I have regarding the treatment.

**I understand that no guarantees have been made to me that this operation will improve my condition.**

Name: Date: Time:

(PATIENT SIGNATURE)

Patient is unable to sign because:

Name: Date: Time:

(If patient unable to sign, person authorized to sign.)

Name: Date: Time:

(Witness to Signature or Telephone Consent Only)

Name: Date: Time:

(Second Witness to Telephone Consent Only)

Interpreted By:

Date: Time:

(Interpreted By)

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|---|---|---|---|
| Patient Name: | | Patient#: | |
| MR#: | | Attending physician: | |
| Admission Date: | | DOB: | |
| Gender: | | Age: | |