Toxopheresis® Protocol

Date _____

Clinic _____

LOT-Number Set _____

LOT-Number Tubing _____

Treatment Protocol

Toxopheresis®

Patient, Name _____

Date of Birth_____ | Weight: _____ kg | Height: _____cm | Hkt: _____% | P-Vol: ___

Treatment No.: ___

Plasma Exchange Volume:
100% = _____ liters | 75% =_____

Treatment Team: Dr. _____ | Nurse _____

Clinical Information

Allergies	Medications	Shaldon Catheter

Anticoagulation

Anticoagulant / Dose: Heparin Sodium

	Before Apheresis	Additional Dosis (if necessary)	Additional Dosis (if necessary)
IU			

Additional Medication / Infusions (before / during / after apheresis) (if necessary)

☐ ___ 250 ml NaCl 0.9% + ___ g / ___ ml Vitamin C + 1 Amp. B1 + ___ Amp. B6 + ___ mg Glutathione OR ___ Amp. Eumetabol 3 g

☐ 250 ml NaCl 0.9% + 1 Pack Citric Acid Cycle + 1 Amp. Ubichinon + 2 Amp. ATP + ___ Lysin i.v.

☐ 1 Amp. Solidago + 1 Amp. Hepar comp + 1 Amp. Lymphomyosot before plasma return

☐ ___ 500 ml Ringer | ☐ 250 / ☐ 500 ml NaCl 0.9%

☐ ___ 100 / ☐ 500 ml Glucose 5% + ___ Amp. Glucose 40%

☐ 1 Amp. Ranitic + 1 Amp. NaCl 0.9% i.v. | ☐ 1 mg Fenistil i.v. | ☐ 1 Amp. Methylcobalamin

☐ 1 Tab. Methylfolate 400 µg (bioactive folic acid)

☐ 1A. Methylcobalamin pre-mixed in 100 ml NaCl 0.9%

Treatment / Vital Parameter

Time (h)	Blood Flow	Plasma Percentage (max. 30%)	TMP (mmHg)	TMP 2 (mmHg)	Arterial pressure (mmHg)	Venous pressure (mmHg)	Blood Sugar (mg%)	Pulse	RR (mmHg) Leg	SO_2 (%)

1.Filter Flushing (after 1100 ml plasma)	please tick ☐	2.Filter Flushing (50 -100 ml plasma befor end of the treatment or necessary)	please tick ☐

Comments:

_____ _____

(Signature Doctor) (Signature Nurse)