Transfusion Medicine Associates
851 Burlway Road Ste. 308
Burlingame, CA 94010

Consent for LDL-Apheresis

I ______________________ hereby consent to have LDL-Apheresis performed on me by the doctors and trained staff of Transfusion Medicine Associates.

It has been explained to me that this procedure consists of drawing blood from a vein into a hollow fiber membrane plasma separator where the plasma is separated from the red cells. The plasma then flows to one of the two dextran sulfate cellulose adsorption columns where the LDL-cholesterol is removed. The plasma is then recombined with the red cells and returned to me. A measured amount of heparin is added to the blood as it is being drawn to prevent clotting. The LDL-Apheresis machine is an automated system that checks and controls the procedure from start to finish. All tubing and columns are sterile and are only used once.

I have been informed and understand that certain adverse reactions could occur during the procedure, including low blood pressure, bruising, blood loss, bleeding, headache, hives, sweating, nausea, chest pain, and death. I also grant permission to staff of Transfusion Medicine Associates to perform those treatments needed to maintain my well being should adverse circumstances arise.

I have received a copy of Post-Apheresis Care Instructions.

I understand that this treatment does not take the place of my prescribed diet and drugs.

I have read and understand this consent. I have had an opportunity to ask questions about this procedure and my questions have been answered to my satisfaction.

Patient's Signature ________________________ Date __________________

RN Witness to Signature ______________________ Date _______________