AUTOMATED RED-CELL EXCHANGE REFERRAL FORM

Patient Name:		**D.O.B:**	
Gender:		**Diagnosis:**	
Mobile number:			
Landline number:			
Address including postcode:			
GP name:			
GP address including postcode:			
Referring Consultant:			
Hospital address including postcode:		**Mobile:**	
		Fax number:	
Emails of any of the team who would like to receive the results:			
CNS name and contact details:			
Relevant past medical and social history (please include current ferritin level)			
Indication for automated red cell exchange:			
Current I.V. Access			
Current transfusion regimen including frequency:	**Simple transfusions:** **Manual exchanges:** **Automated red cell exchange:** **Other:**		

Transfusion history: **Where have previous transfusions been given?** **Antibodies?**	
Genotype/ Phenotype	

Authorisation
The patient above will undergo a one off automated red cell exchange (Auto-REX) or regular exchanges using the Optia Spectra apheresis system. All other care remains the responsibility of the referring hospital if the patient is accepted for treatment.

Name:	
Date:	

The following section to be completed by the UCLH Consultant Haematologist on accepting the patient onto the AUTO-REX programme

TARGETS	
PRE HbS: % **POST HbS: %**	**Hb g/l post procedure** **Hb not to be raised >20g/l during the procedure.**
Planned frequency 4-8 weekly depending on the patient response YES/NO	
Future plan including future review date:	
Name of Consultant:	
Date	