



GROUPE CANADIEN  
D'APHÉRÈSE

CANADIAN APHERESIS  
GROUP

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**The Canadian Apheresis Group  
and  
The Canadian Association of Apheresis Nurses  
2010 Annual Reporting Forms and ICD Code List**



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Reporting Forms 2010,

1. Plasma Exchange Procedures
2. TTP Patients
3. Photopheresis
4. Cytapheresis Report
5. Columns Use
6. Stem Cell Collections
7. Severe Reactions
8. Outcome
9. The list of ICD Codes

Please save the file so you can print new forms as needed.

These forms will also be on the website at <http://www.apheresis.ca/>

**CANADIAN APHERESIS GROUP  
PLASMA EXCHANGE REPORT FORM**

Revised January 2010  
2 pages and ICD Codes

1. Physician:	2. Center:	3. Date of Procedure: (dd/mm/yy)
4. Pt ID#:	5. D.O.B. (mm/dd/yy)	6. Sex: <input type="checkbox"/> M <input type="checkbox"/> F
7. Diagnosis		ICD Code# (see attached):
8. Specific indication for PE if different from above		
9. Is this the first procedure for this indication? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, What number?		
10. Patient condition: <input type="checkbox"/> Satisfactory <input type="checkbox"/> Complicated > Explain:		
11. If the patient has TTP/HUS - Is/has the patient received medication for: Hypertension? <input type="checkbox"/> Yes <input type="checkbox"/> No angina? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient receiving platelet transfusions? <input type="checkbox"/> Yes <input type="checkbox"/> No		
12. Is the patient premedicated? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes specify: Is the patient medicated during the procedure? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes specify: Is the patient receiving steroids? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes specify:		
13. Machine <input type="checkbox"/> H30 <input type="checkbox"/> HV50 <input type="checkbox"/> TPE <input type="checkbox"/> Spectra <input type="checkbox"/> Other:		
14. Vascular Access: <input type="checkbox"/> Peripheral Vein <input type="checkbox"/> Catheter <input type="checkbox"/> Other:		
15. Anticoagulant: <input type="checkbox"/> ACD-A <input type="checkbox"/> ACD-B <input type="checkbox"/> Citrate <input type="checkbox"/> Other:		
16. Replacement Fluid: <input type="checkbox"/> FFP _____ ml <input type="checkbox"/> Cryosupernatant _____ ml <input type="checkbox"/> Albumin _____ ml <input type="checkbox"/> Saline _____ ml <input type="checkbox"/> SDP _____ ml <input type="checkbox"/> Anticoagulant _____ ml <input type="checkbox"/> Lactated Ringer _____ ml <input type="checkbox"/> Other: _____ ml <input type="checkbox"/> Pentaspan _____ ml <input type="checkbox"/> Specify:		
If the diagnosis is NOT TTP/HUS, and plasma was used as there placement fluid, please indicate the reason:		
17. Total volume replaced _____ ml Total volume removed _____ ml		
18. Did the patient experience an adverse reaction? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, specify		
Fill in the severe reaction form if appropriate.		



**TTP/HUS Report Form**

To be completed for any patient diagnosed with TTP or HUUS whether or not they are entered in a CAG study. If the patient is entered in a study, please record study name and ID#: \_\_\_\_\_

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**1. Patient Information**

- a) Patient ID# \_\_\_\_\_ b) Patient initials: \_\_\_\_\_  
c) Date of birth (dd/mm/yy): \_\_\_\_\_ d) Sex: M  F   
e) Date of entry (dd/mm/yy): \_\_\_\_\_ f) Blood Pressure: \_\_\_\_\_  
g) Age: \_\_\_\_\_ h) Height: \_\_\_\_\_  
i) Weight: \_\_\_\_\_  
j) Race: Caucasian  African American  Asian  Other: \_\_\_\_\_
- 

**2. Center Information**

- a) Attending physician: \_\_\_\_\_ b) Phone #:( ) \_\_\_\_\_  
c) Hospital: \_\_\_\_\_ d) City: \_\_\_\_\_  
e) Hospital ID#: \_\_\_\_\_
- 

**3. Diagnostic Criteria – measured pre-first exchange or on diagnosis**

- a) Platelet count: \_\_\_\_\_ x 10<sup>9</sup> /L  
b) RBC fragmentation of blood smear?  
Yes  No   
c) Hemoglobin: \_\_\_\_\_ g/L  
d) Reticulocytes: \_\_\_\_\_ x 10<sup>9</sup>/L  
e) BUN: \_\_\_\_\_ mol/L AND/OR Creatinine: \_\_\_\_\_ mol/L  
f) Bilirubin: \_\_\_\_\_ mol/L  
g) LDH: \_\_\_\_\_  
h) Protein S: \_\_\_\_\_
- 

**4. Additional Clinical Information**

- a) Fluctuating neurological abnormalities present: Yes  No   
If yes, please specify:

b) Significant (>38.5EC) fever present in the past 48 hrs: Yes  No   
 If yes, specify maximum: \_\_\_\_\_ °C

c) Did the patient have any of the following symptoms prior to hospitalization?

	Yes	No	NR	Date of onset (dd/mm/yy)
Fever				
Upper respiratory infection				
Diarrhea				
Chest pain				
Abdominal pain				
Mental status changes, confusion				
Seizures				
Infection within the last 12 weeks				
Blood in stools				
Vomiting				
Cold or flu-like symptoms				
Sore throat				
Cough				
Vaginal discharge/urethritis				
Bladder infection				

d) Hemorrhagic diarrheal illness in past 6 weeks: Yes  No

e) Dialysis treatment: Yes  No

**5. Prior History of TTP**

a) Is this the first episode of TTP: Yes  No

b) Date of prior episode(s) of TTP (dd/mm/yy): \_\_\_\_\_

**6. Prior treatment of TTP episodes**

a) Prior PE treatment:

Plasma exchange: Yes  No  Number: \_\_\_\_\_

Date (dd/mm/yy): \_\_\_\_\_

Replacement fluid: \_\_\_\_\_

Plasma infusion: Yes  No  Number: \_\_\_\_\_

Date (dd/mm/yy): \_\_\_\_\_

Other: \_\_\_\_\_

b) Corticosteroids: Yes  No  Date (dd/mm/yy): \_\_\_\_\_

c) Rituximab: Yes  No  Date (dd/mm/yy): \_\_\_\_\_

d) Other immunosuppressants: Yes  No  Date (dd/mm/yy): \_\_\_\_\_

List: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

e) Splenectomy: Yes  No

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## 7. Family History

a) Is there a family history of TTP or HUS: Yes  No

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## 8. Past Medical History

a) Hypertension: Yes  No

b) Coronary artery disease: Yes  No

c) History of venous thrombosis (DVT or PE): Yes  No

d) History of MI: Yes  No

e) History of CVA: Yes  No

f) Systemic Lupus Erythematosus: Yes  No

g) Other autoimmune disorder(s): Yes  No

List: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

h) HIV: Yes  No

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## 9. Medication Prior to Hospitalization

a) Has the patient taken any new medication (including antibiotics or contraceptive pills) during the two-week period prior to hospitalization: Yes  No

If yes, please give the names of medications, when first started and the dosage:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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## 10. In the 12 weeks prior to admission has the patient received:

a) ACE inhibitors: Yes  No

Aspirin: Yes  No

Ticlopidine: Yes  No

Renal Transplant: Yes  No

Cyclosporin: Yes  No

Immunosuppressive therapy: Yes  No

Platelet transfusions: Yes  No

Stem cells or bone marrow  
transplant in the last year: Yes  No

b) Herbal or other supplements: Yes  No

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### 11. Pregnancy

a) Is the patient pregnant: Yes  No

b) Recent childbirth or miscarriage: Yes  No

If yes, please give dates and nature of complications, if any:

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### 12. Current Treatment

a) Start date of this plasma exchange session (dd/mm/yy): \_\_\_\_\_

b) Vascular access for TPE (choose one):

Central:  Peripheral:

c) Location of central access (choose one):

Internal jugular vein:  Subclavian vein:  Femoral vein:

d) Fresh frozen plasma transfused prior to start of TPE: Yes  No

Number of units: \_\_\_\_\_ Date(s): \_\_\_\_\_

e) Red blood cells transfused prior to the start of TPE: Yes  No

Number of units: \_\_\_\_\_ Date(s): \_\_\_\_\_

f) Platelets transfused prior to the start of TPE: Yes  No

Number of units: \_\_\_\_\_ Date(s): \_\_\_\_\_

g) Total number of treatments: \_\_\_\_\_ Date of last treatment: \_\_\_\_\_

**CANADIAN APHERESIS GROUP EXTRACORPOREAL  
PHOTOPHERESIS REPORT FORMS**

Date: \_\_\_\_\_ Dx: \_\_\_\_\_

Treatment # \_\_\_\_\_ Wt: \_\_\_\_\_ kg x \_\_\_\_\_ = TBV \_\_\_\_\_ mL  
(Body build factor)

Safe Extracorporeal Volume Range: \_\_\_\_\_ to \_\_\_\_\_ mL  
(TBVx0.1) (TBVx0.15)

Peak Extracorporeal Volume: \_\_\_\_\_ mL (+ 100 mL if abnormal RBC)  
(Cycle #5 for XT125 bowl or #1 for XT001 bowl)

Bowl Selected: XT001 , XT125 , Number of Cycles: \_\_\_\_\_

Collection Rate \_\_\_\_\_ mL/min, Return/Reinf. Rate \_\_\_\_\_ mL/min

A/C ratio \_\_\_\_\_ :1, IV Access \_\_\_\_\_

**Pre-Procedure Condition:**

VS: T \_\_\_\_\_ P \_\_\_\_\_ BP \_\_\_\_\_ R \_\_\_\_\_ SpO2 \_\_\_\_\_ %

Hb \_\_\_\_\_ WBC \_\_\_\_\_ Plt \_\_\_\_\_ PCV \_\_\_\_\_ Bilirubin \_\_\_\_\_

Comments \_\_\_\_\_

Blood leak alarm passed	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lamp Hrs	
Instrument S/N (XTS)	
Inst. Hrs	
Kit Lot #	Exp
NS Lot #	Exp
NS Lot #	Exp
Heparin Lot #	Exp
UVADEX Lot #	Exp

Is Patient Suitable for ECP Treatment?  Yes  No

Procedure Started at: \_\_\_\_\_ **Collection Data**

Cycle	Flow Rate (mL/min)	Treatment Volume	End of Cycle Time	Vital Signs			Comments
#1				P	BP	R	
#2				P	BP	R	
#3				P	BP	R	
#4				P	BP	R	
#5				P	BP	R	
#6				P	BP	R	

**Photo-Activation**

UVADEX Dose	Final Vol	x0.017= _____ mL x 20 = _____ mcg	Time injected:	RN:
Comments:			Post Photo-Activation VS:	Time
			T P BP R SpO2 %	

**Manual Return of Residual RBC:**  Yes  No, **CVC Locked:**  N/A,  Yes \_\_\_\_\_

**Fluid balance:** NS \_\_\_\_\_ mL + A/C \_\_\_\_\_ mL = \_\_\_\_\_ mL -100 mL (if No Manual Return) = \_\_\_\_\_ mL

**Heparin Intake:** \_\_\_\_\_ i.u. / NS 500 mL x A/C \_\_\_\_\_ mL = \_\_\_\_\_ i.u.

Patient was instructed to wear UVA sunglasses and sunscreen for 24 hrs post treatment:  Yes  No  
Data Key retained to send to Therakos for analysis (only required if incomplete treatment):  Yes  No

**D/C Time:** \_\_\_\_\_, Ambulate:  Yes,  No, WC:  Yes,  No, Accompanied:  Yes,  No,  
**RN Signature:** \_\_\_\_\_

**CANADIAN APHERESIS GROUP  
CYTAPHERESIS REPORT FORM**

Revised January 2010

1. Physician:	2. Center:	3. Date of Procedure: (dd/mm/yy)
4. Pt ID#:	5. D.O.B. (mm/dd/yy)	6. Sex: <input type="checkbox"/> M <input type="checkbox"/> F
7. Diagnosis		ICD Code# (see attached):
8. Specific indication for procedure if different from above		
9. Is this the first procedure for this indication? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, What number?		
10. Patient condition: <input type="checkbox"/> Satisfactory <input type="checkbox"/> Complicated > Explain:		
11. Cells removed:		
	RBC <input type="checkbox"/>	Gran <input type="checkbox"/>
	WBC <input type="checkbox"/>	Lymph <input type="checkbox"/>
	PLTS <input type="checkbox"/>	Other _____
12. Is the patient premedicated? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes specify: Is the patient medicated during the procedure? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes specify:		
13. <input type="checkbox"/> HV50 <input type="checkbox"/> TPE <input type="checkbox"/> Spectra Other: _____		
14. Vascular Access: <input type="checkbox"/> Peripheral Vein <input type="checkbox"/> Catheter <input type="checkbox"/> Other:		
15. Anticoagulant: <input type="checkbox"/> ACD-A <input type="checkbox"/> ACD-B <input type="checkbox"/> Citrate <input type="checkbox"/> Other:		
16. Total volume processed _____ ml		
17. Did the patient experience an adverse reaction? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, specify		
Fill in the severe reaction form if appropriate.		

**CANADIAN APHERESIS GROUP  
COLUMN APHERESIS PROCEDURES  
REPORTING FORMS**

Revised January 2010

1. Physician:	2. Center:	3. Date of Procedure: (dd/mm/yy)
4. Pt ID#:	5. D.O.B. (mm/dd/yy)	6. Sex: <input type="checkbox"/> M <input type="checkbox"/> F
7. Diagnosis		ICD Code# (see attached):
8. Specific indication for treatment if different from above		
9. Is this the first procedure for this indication? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, What number?		
10. Column Used:		
LDL Asahi <input type="checkbox"/>	GI Otsuka <input type="checkbox"/>	
LDL Other <input type="checkbox"/>	Abody Staph A <input type="checkbox"/>	
Specify: _____	Specify: _____	
10. Patient condition: <input type="checkbox"/> Satisfactory <input type="checkbox"/> Complicated > Explain:		
11. Is the patient premedicated? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes specify: Is the patient medicated during the procedure? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes specify:		
12. Vascular Access: <input type="checkbox"/> Peripheral Vein <input type="checkbox"/> Catheter <input type="checkbox"/> Other:		
13. Anticoagulant: <input type="checkbox"/> ACD-A <input type="checkbox"/> ACD-B <input type="checkbox"/> Citrate <input type="checkbox"/> Other:		
14. Total volume processed _____ ml Duration of procedure _____ minutes		
15. Did the patient experience an adverse reaction? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, specify		
Fill in the severe reaction form if appropriate.		



## SUBSEQUENT PROCEDURES...

Procedure #	2	3	4	5	6	7	8
Date (y-m-d)							
Cytotoxic Priming Y / N (specify)							
Growth Factor Priming Y / N (specify)							
WBC count prior to procedure							
Machine							
Vascular Access							
Anticoagulant/ Blood ratio							
Blood volume processed (ml)							
Volume of concentrate (ml)							

REACTIONS OR SIDE EFFECTS REQUIRING INTERRUPTION OF THE PROCEDURE:

Describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Occurred during procedure(s) #: \_\_\_\_\_

Please return this form to:  
 The Coordinator, Canadian Apheresis Group  
 199-345 St. Laurent Blvd.  
 Ottawa, ON K1K 2Z8

## CANADIAN APHERESIS GROUP SEVERE REACTION REPORTING FORM

A severe reaction is one in which the patient becomes clinically unstable requiring intervention by a physician and termination of the procedure.

Patient ID	D.O.B (d/m/y)	Gender	Date of Procedure (d/m/y)	Centre	Physician
Diagnosis	Indication	ICD code	Co-morbid conditions		
TPE #	Time into the procedure				
Reaction Description					
Clinical Data		Pre	Post		
	BP				
	Pulse				
	O2 Sat				
	Temp				
Other relevant findings					
TPE Data	Fluid Type			% Balance	
	Total volume infused including procedural fluids etc.	Total volume removed	Actual fluid balance in mls		
	Pre-medication				
Lab data		Pre	Post		
	Na				
	K				
	Ca				
	Hgb & Hct				
	WBC				
	Plt				
Other relevant labs					
Intervention					
Outcome					
Physician's Comments and Reaction interpretation					
Physician's signature					

## CANADIAN APHERESIS GROUP HEALTH SURVEY

### To be completed by Nursing Staff

Patient ID # \_\_\_\_\_ Diagnosis: \_\_\_\_\_  
 Date of initial diagnosis \_\_\_\_\_ Reason for PE \_\_\_\_\_  
 This treatment cycle began on \_\_\_\_\_ and continued until \_\_\_\_\_  
 How many previous cycles of PE has the patient had? \_\_\_\_\_  
 Total number of plasma exchanges for this treatment cycle: \_\_\_\_\_  
 The replacement fluid used: \_\_\_\_\_  
 Other medication that was used \_\_\_\_\_  
 Outcome of this cycle:    Excellent            Good            Fair            Poor  
 Patient will complete this form 3 months following the last treatment which will be \_\_\_\_\_

**Instructions for patients:** The Canadian Apheresis Group needs your help to determine the effectiveness of the plasma exchange therapy you have received. Please answer every question. If you are unsure about how to answer a question, please give the best answer you can. Please complete the form on the date above and send it to us. Thank you.

1. In general, would you say your health is now:

- a) Excellent            b) Very Good            c) Good            d) Fair            e) Poor

2. Does your health keep you from working at a job, doing work around the house or going to school?

- a) Yes, for the past 3 months            b) Yes, less than 3 months            c) No

3. For each of the following questions, please check the box for the one answer that most correctly describes your situation.

	Definitely True	Mostly True	Not Sure	Mostly False	Definitely False
a) I am somewhat ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) I am as healthy as anybody I know	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) My health is excellent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) I have been feeling bad lately	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) I have required further treatment for my disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

f) I have required further treatment with drugs            **Yes**            **No**

g) Did your further treatment include plasma exchange?            **Yes**            **No**

h) What other treatment did you require? \_\_\_\_\_

i) When was this given? \_\_\_\_\_

j) If the patient has passed away, please indicate the date and cause of death: \_\_\_\_\_

4. For each of the following questions, please check the box for the one answer that comes closest to the way you have been feeling **during the past month**. (Check one box on each line)

## CANADIAN APHERESIS GROUP HEALTH SURVEY

### To be completed by Nursing Staff

Patient ID # \_\_\_\_\_ Diagnosis: \_\_\_\_\_  
 Date of initial diagnosis \_\_\_\_\_ Reason for PE \_\_\_\_\_  
 This treatment cycle began on \_\_\_\_\_ and continued until \_\_\_\_\_  
 How many previous cycles of PE has the patient had? \_\_\_\_\_  
 Total number of plasma exchanges for this treatment cycle: \_\_\_\_\_  
 The replacement fluid used: \_\_\_\_\_  
 Other medication that was used \_\_\_\_\_  
 Outcome of this cycle:    Excellent            Good            Fair            Poor  
 Patient will complete this form 3 months following the last treatment which will be \_\_\_\_\_

**Instructions for patients:** The Canadian Apheresis Group needs your help to determine the effectiveness of the plasma exchange therapy you have received. Please answer every question. If you are unsure about how to answer a question, please give the best answer you can. Please complete the form on the date above and send it to us. Thank you.

1. In general, would you say your health is now:

- a) Excellent            b) Very Good            c) Good            d) Fair            e) Poor

2. Does your health keep you from working at a job, doing work around the house or going to school?

- a) Yes, for the past 3 months            b) Yes, less than 3 months            c) No

3. For each of the following questions, please check the box for the one answer that most correctly describes your situation.

	Definitely True	Mostly True	Not Sure	Mostly False	Definitely False
a) I am somewhat ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) I am as healthy as anybody I know	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) My health is excellent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) I have been feeling bad lately	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) I have required further treatment for my disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

f) I have required further treatment with drugs            **Yes**            **No**

g) Did your further treatment include plasma exchange?            **Yes**            **No**

h) What other treatment did you require? \_\_\_\_\_

i) When was this given? \_\_\_\_\_

j) If the patient has passed away, please indicate the date and cause of death: \_\_\_\_\_

4. For each of the following questions, please check the box for the one answer that comes closest to the way you have been feeling **during the past month**. (Check one box on each line)

	All of the Time	Most of the Time	A Good Bit of the Time	Some of the Time	A Little of the Time	None of the Time
a) How much of the time has your health limited your social activities (like visiting friends or close relatives)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) How much of the time have you been a very nervous person?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) How much of the time have you felt calm and peaceful?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) How much of the time have you felt downhearted and blue?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

This form was completed on \_\_\_\_\_ Please indicate your postal code \_\_\_\_\_



Place Stamp
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RETURN TO

Canadian Apheresis Group  
435 St. Laurent Blvd., Suite 199  
Ottawa, Ontario  
K1K 2Z8

Fold here

## DIAGNOSES AND ICD CODES

DIAGNOSIS	ENTRY INSTRUCTIONS?	ICD CODE	CATEGORY
Arron Syndrome	Enter as SLE	710.0	Collagen-Vascular
Arteritis	Polyarteritis nodosa	447.6	Collagen-Vascular
Dermatomyositis (Polymyositis with skin involvement)		710.3	Collagen-Vascular
Immune Complex Vasculitis	Enter as vasculitis( unspecified)	447.6	Collagen-Vascular
Mixed Connective Tissue Disease (MCTD)		710.8	Collagen-Vascular
Polyarteritis nodosa	Polyarteritis nodosa	447.6	Collagen-Vascular
Polymyositis		710.4	Collagen-Vascular
Raynaud's Syndrome		443.0	Collagen-Vascular
Rheumatoid Arthritis		714.0	Collagen-Vascular
Scleroderma		710.1	Collagen-Vascular
Sicca syndrome		710.2	Collagen-Vascular
Sjogrens Disease		710.2	Collagen-Vascular
Systemic Lupus Erythematosus (SLE)		710.0	Collagen-Vascular
Systemic sclerosis	Enter as Scleroderma	710.1	Collagen-Vascular
Vasculitis (unspecified)		447.6	Collagen-Vascular
Dermatitis Herpetiformis		694.0	Dermatological
Dermatoses Bullous		694.4	Dermatological
Pemphigus		694.4	Dermatological
Pyoderma (specified)		686.00	Dermatological
Pyoderma gangrenosum		686.01	Dermatological
Biliary Cirrhosis		571.6	Gastroenterological
Cholestastis		575.8	Gastroenterological
ABO Incompatible Bone Marrow		996.85	Hematology
Agammaglobulinemia (Deficiency of Humoral Immunity)		279.0	Hematology
AML acute myelogenous leukemia		205	Hematology
Aplastic Anemia		284.0	Hematology
Autoimmune Hemolytic Anemia (Cold Agglutinin Disease or Hemoglobinuria)		283.0	Hematology
Blackfan-Diamond Syndrome	Enter as Red Cell Aplasia	284.0	Hematology
Bone Marrow Hypoplasia		284.9	Hematology
Chronic lymphoid leukemia (CLL)		204.10	Hematology
Coagulopathy		286.6	Hematology
Cold Agglutinin Disease	Enter as Autoimmune Hemolytic Anemia	283.0	Hematology
Cryoglobulinemic Vasculitis	Enter as Cryoglobulinemic	273.2	Hematology
Cyroglobulinemia (mixed)		273.2	Hematology

## DIAGNOSES AND ICD CODES

DIAGNOSIS	ENTRY INSTRUCTIONS?	ICD CODE	CATEGORY
Deficiency of Humoral Immunity	Enter as Agammaglobulinemia	279.0	Hematology
DIC (disseminating intravascular coagulopathy)		286.6	Hematology
Factor VIII Antibodies		999.8	Hematology
Hemoglobinuria	Enter as Autoimmune Hemolytic Anemia	283.0	Hematology
Hemolytic anemia of adult		282.3	Hematology
Hemolytic anemia of newborn		773.0	Hematology
HUS Hemolytic Uremic Syndrome		283.1	Hematology
Hyperviscosity	Enter as Waldenstrom's Macroglobulinemia	273.3	Hematology
Hypogammaglobulinemia (unspecified immunodeficiency)		279.00	Hematology
Hypogammaglobulinemia IgA		279.01	Hematology
Hypogammaglobulinemia IgM		279.02	Hematology
Hypogammaglobulinemia other (IgG)		279.03	Hematology
Hypoplastic Anemia (Bone Marrow Hypoplasia)		284.9	Hematology
Idiopathic Thrombocytopenic Purpura (ITP)		287.3	Hematology
IgA Myeloma		203.0	Hematology
Leukemia		204.0	Hematology
Macroglobinemia		273.3	Hematology
Monoclonal Paraproteinemia		273.1	Hematology
Multiple Myeloma		203.0	Hematology
Red Cell Aplasia (pure) (Blackface-Diamond Syndrome)		284.0	Hematology
Rh Disease		773.0	Hematology
Sickle Cell anemia	French anemia foliiform	282.60	Hematology
Thrombotic Microangiopathy	Enter as TTP	446.6	Hematology
Thrombotic Thrombocytopenic Purpura (TTP)		446.6	Hematology
TTP post BMT		446.6	Hematology
TTP Relapse		446.6	Hematology
TTP Vasculitis		446.6	Hematology
Waldenstrom's Macroglobulinemia (Hyperviscosity)		273.3	Hematology
Devic's Syndrome		340	Metabolic
Diabetic Retinopathy		250.4	Metabolic
Graves' Disease (Toxic Diffuse Goitre)		242.0	Metabolic
Hypercholesterolemia (Hyperlipidemia, Group A)		272.0	Metabolic
Hyperlipidemia (unspecified)		272.4	Metabolic
Hyperlipidemia, Group A	Enter as Hypercholesterolemia	272.0	Metabolic
Hypertriglyceridemia		272.4	Metabolic

## DIAGNOSES AND ICD CODES

DIAGNOSIS	ENTRY INSTRUCTIONS?	ICD CODE	CATEGORY
Porphyria		277.1	Metabolic
Toxic diffuse goiter	Enter as Graves' Disease	242.0	Metabolic
Acute demyelinating syndrome		000.0	Miscellaneous
Antiphospholipid syndrome		286.5	Miscellaneous
Cancer of optic nerve		192.0	Miscellaneous
Cerebral Malaria		084.9	Miscellaneous
Dyslipidemia		000.0	Miscellaneous
Epstein Barr (EBV)( infectious mononeucleosis)		075.0	Miscellaneous
Fulminating liver failure post partum		572.8	Miscellaneous
HELLP		000.0	Miscellaneous
Hodgkins Lymphoma		357.8	Miscellaneous
Infectious Mononeucleosis	Enter as Epstein Barr	075.0	Miscellaneous
Lung transplant		996.84	Miscellaneous
Lymphoma		357.8	Miscellaneous
Miscellaneous		000.0	Miscellaneous
Monoclonal Gammopathy		356.9	Miscellaneous
Non Hodgkins lymphoma		202.80	Miscellaneous
Poem's syndrome		000.0	Miscellaneous
Poisoning		989.9	Miscellaneous
Stiffman syndrome (Stiff person)		000.0	Miscellaneous
TMA-2 (transplant related)		000.0	Miscellaneous
Acute Guillain-Barre Syndrome (AGB) (Acute Infective Polyneuritis)		357.0	Neurological
Acute Infective Polyneuritis	Enter as Acute Guillain-Barre Syndrome	357.0	Neurological
Chronic Guillain-Barre Syndrome (Chronic Polyneuropathy)		357.8	Neurological
CIDP (chronic inflammatory demyelinating polyneuritis)		357.8	Neurological
CIDPN (chronic idiopathic peripheral neuropathy)		356.9	Neurological
Eaton-Lambert Syndrome	Enter as Myasthenic Syndrome	358.1	Neurological
Encephalitis (unspecified)		323.0	Neurological
Encephalitis post viral		323.6	Neurological
Encephalomyelitis (myelitis)		323.9	Neurological
LGB		357.0	Neurological
Miller Fisher neuropathy		357.0	Neurological
Multiple Sclerosis	French sclerose en plaque	340	Neurological
Myasthenic Gravis		358.0	Neurological
Myasthenic Syndrome (Eaton-Lambert Syndrome)		358.1	Neurological

## DIAGNOSES AND ICD CODES

DIAGNOSIS	ENTRY INSTRUCTIONS?	ICD CODE	CATEGORY
Myelitis		323.9	Neurological
Neuropathy		356.9	Neurological
Peripheral neuropathy (idiopathic)		356.9	Neurological
Polyneuropathy		357.8	Neurological
Sydenham's Chorea		392.9	Neurological
Transverse Myelitis		357.0	Neurological
Drug Overdose		977.9	Pharmacological
Acute renal failure		584.5	Renal
Acute renal transplant rejection	Transplant rejection(renal)	996.8	Renal
Allergic Purpura	Enter as Henoch Schonlein Purpura	287.0	Renal
Anti-GBM	Enter as Goodpasture's syndrome	446.2	Renal
Churg Strauss syndrome	Enter as Wegeners	446.4	Renal
Fabrey's		272.7	Renal
FSGS		583.9	Renal
Glomerulonephritis (other than RPGN)		583.9	Renal
Goodpasture's Syndrome (anti-GBM)	(Delete Hypersensitivity angiitis)	446.2	Renal
Henoch-Schonlein Purpura		287.0	Renal
Hypersensitivity Angitis	Enter as microscopic polyangiitis	446.2	Renal
Kidney Failure	Enter as Renal failure	996.8	Renal
Kidney transplant	Enter as transplant rejection(renal)	996.0	Renal
Light chain Disease (Monoclonal Paraproteinemia)		273.1	Renal
Myeloma kidney		203	Renal
Nephrotic syndrome		583.9	Renal
Pre-transplant	Pre-transplant hypersensitized recipient	996.8	Renal
Rapidly Progressive Glomerulonephritis (RPGN)		583.4	Renal
Renal failure (Kidney Failure)		996.8	Renal
Renal transplant (Kidney transplant)		996.0	Renal
Renal transplant rejection	Enter as Transplant Rejection (Renal)	996.8	Renal
Transplant Rejection (Heart)		996.83	Renal
Transplant rejection (Liver)		996.82	Renal
Transplant Rejection (Renal)		996.8	Renal
Vascular rejection of kidney	Humeral transplant rejection (renal)	996.8	Renal
Wegener's Granulomatosis (Churg Strauss syndrome)		446.4	Renal
Crohn's Disease	Regional enteritis	555.9	Gastroenterological