



HLA MATCHED PLATELETS/CROSS-MATCHED (CXM)
PLATELETS /PLATELET ANTIBODY SCREEN REQUEST FORM

Hospital: _____ Phone#: _____ Fax#: _____

Requested: Date: _____ Time: _____ Requested By (Hospital Staff): _____

Patient Information (Client to Complete)

Name (Last, First)	Date of Birth	Medical Record Number	ABO/Rh Type	Gender
				<input type="checkbox"/> Male <input type="checkbox"/> Female

Current Platelet Count: _____ x 10¹¹ Date: _____ Active bleeding: Yes No Site: _____

Transfusions History: # of Platelet Transfusions: _____ Most recent dates(s): _____

Prior HLA/Platelet Antibody Screen: No Yes Date _____ Results _____

CLINICAL INFORMATION: Are there other factors contributing to platelet refractoriness? (check all that apply):

- Fever Infection Patient on anti-fungal therapy
 Enlarged spleen Evidence of DIC Other: _____ (explain)

Products Requested (Indicate by a check mark)

PRODUCT REQUESTED:	<input type="checkbox"/> Cross Matched Platelets (Patient Sample Required) Minimum: 1 x 7mL EDTA plasma or serum
	<input type="checkbox"/> HLA Matched Platelets (Patient's HLA typing must be provided) Patient's HLA Typing: _____ (Document and Fax Patient's HLA Typing)
ADDITIONAL PRODUCT REQUIRMENTS:	ABO/Rh Type Specific: <input type="checkbox"/> Yes <input type="checkbox"/> No CMV Neg: <input type="checkbox"/> Yes <input type="checkbox"/> No Irradiated: <input type="checkbox"/> Yes <input type="checkbox"/> No Other: _____ (Indicate)
# of Units Requested: _____ Units Needed By: _____	

Testing Requested (Indicate by a check mark, Patient Sample Required)

<input type="checkbox"/> Platelet Antibody Screen	<input type="checkbox"/> Platelet Antibody Identification (I.D.)
If Applicable: Sample ID: _____ Collection Date: _____ Collection Time: _____	
Sample Type (indicate # of tubes): <input type="checkbox"/> EDTA Plasma _____ <input type="checkbox"/> Serum _____ <input type="checkbox"/> Other _____ (if Applicable) Minimum: 1 x 7mL EDTA plasma or serum for Each Assay.	

Vitalant Staff Notification ONLY

Information Received By: _____	Date/Time: _____
Sample Received By: _____ Date/Time: _____	
Sample Integrity: <input type="checkbox"/> Acceptable <input type="checkbox"/> Unacceptable Comments: _____	

Reference/Tech. Services Laboratory: Phone #: 201.251-3975 Fax: 201-573-4625

Note: Ship samples at room temperature. Plasma should be separated from the red cells if not shipped immediately. Samples must be received within 24 hours of post collection to assure testing integrity remains intact. Sample Rejection: Gross hemolysis, sample placed in a serum separator tube, specimen tube not properly labeled, over 48 hours old. Complete reference laboratory request form. A new patient specimen is required every 7 days.