

PLATELET ANTIBODY LAB REQUEST FORM

*Patient's Name/ID _____ Birth Date _____
 *Date Collected _____ *Date Submitted _____ * Sex _____
 *Hospital/Facility _____
 *Physician Requesting Test(s) _____
 Information on test methods, performance specifications and interpretation are available on request.
 *CLIA Required Information, CFR 493.1241

DIAGNOSIS: _____ ABO/Rh TYPE: _____

TRANSFUSION HISTORY: Number of transfusions received: Platelets _____ Red Cells _____

Date of most recent transfusion: Platelets _____ Red Cells _____

PREGNANCY: Is patient now pregnant? _____ Gravida _____ Para _____

DRUG HISTORY: List or attach all medications patient is or has recently received: _____

- 3980 **Platelet Antibody Screen**
Requires 2 mL ACD plasma
- 3982 **Platelet-Bound IgG**
Current Platelet Count _____ (Required)
Requires 7-10 mL ACD whole blood < 24 hours old, unrefrigerated.
If platelet count is < 50,000, call for instructions. Test requires minimum platelet count of 10,000.
- 3980 **Investigate Autoimmune Thrombocytopenia**
3982 **Current Platelet count _____ (Required)**
Sample Requirements: See Platelet Antibody Screen and Platelet – Bound IgG
- 3984 **Platelet Crossmatch**
Number of units requested: _____ Frequency: _____
Special requirements: CMV Neg _____ Other: _____
- 3983 **Investigate Neonatal Immune Thrombocytopenia**
Requires 14-20 mL **Maternal** ACD whole blood, < 24 hours, unrefrigerated.
Current Platelet Count _____ (Required)
Requires 7-10 mL **Paternal** ACD whole blood, < 24 hours, unrefrigerated.
Current Platelet Count _____ (Required)
Samples from the infant are not required.
- 3990 **Investigate Posttransfusion Purpura**
Current Platelet Count _____ (Required)
Requires 7-10 mL ACD whole blood < 24 hours, unrefrigerated.
If platelet count is < 50,000, call for instructions.
- Other** _____

Date: _____ Personnel authorized to request tests/receive results: _____

FAX: _____ Telephone: _____

For CBC Use Only		CROSSMATCHES		
Date Sample Tested _____		Date Tested _____	Number Tested _____	Number Compatible _____
Capture P: Neg _____ Pos _____		_____	_____	_____
Ready P: Neg _____ Pos _____		_____	_____	_____
PBIgG: Neg _____ Pos _____		_____	_____	_____
PAK12G: Neg _____ Pos _____		TOTAL _____	_____	_____
		Comments: _____		

Billing Entered into EI Dorado By: _____ Date: _____

Results Review by: _____ Date: _____

Results Telephoned to Hospital To: _____ Date: _____ By: _____

SEND TO:

**COMMUNITY BLOOD CENTER
PLATELET ANTIBODY LAB
4040 MAIN, KANSAS CITY, MO 64111**

From: _____

Ship: STAT ASAP Routine

Test: STAT ASAP Routine

Please call IRL at 816-968-4053 prior to sending sample.