

IMMUNOHEMATOLOGY LABORATORY
HLA MATCHED PLATELET REQUEST FORM

Patient's Name/ID _____ Birth Date _____
Patient CMV Status: Negative <input type="checkbox"/> Positive <input type="checkbox"/> Unknown <input type="checkbox"/> Sex _____
Hospital/Facility _____
Physician Requesting HLA Matched Product(s) _____
Physician Contact Number(s) _____
Today's Date _____ Patient ABO _____ Rh _____
HLA Type A _____ B _____

HLA Matched Platelets for Transfusion:

Number of units _____ Date and time needed: _____

Non ABO Type-Specific Acceptable? Yes No

Any HLA Match Grade Requirements? *If no, usual match will be grade B or higher.* No Yes please specify _____

Special Requirements:

CMV-negative Irradiated (*ALL HLA matched product require irradiation; check only if CBC needs to irradiate product for hospital*)

Desired Delivery: Routine >2 days STAT <2 days (*due to product availability, IRL cannot guarantee product within 2 days*)

Will accept units negative for known HLA Antibodies? (*Previous HLA Antibody Identification required – please attach report*)

No Yes *known HLA antibodies* _____ Date of Most Recent Test _____

For first time requests, please submit the patient's HLA Type results with this request

➤ *High Resolution Recommended*

Blood Bank Contact Person: _____ Telephone: _____

Fax Form to Immunohematology Reference Laboratory at 816-277-0757

Please call IRL at 816-968-4053 for questions regarding orders and to verify receipt of this request

For CBC Use Only

Billing Entered into El Dorado By: _____

Date: _____