Community Blood Center Administrative Offices: 4040 Main Street Kansas City, Missouri 64111
Phone: 816-968-4097 Fax: 816-277-0757

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

Date Sample Tested _____ CROSSMATCHES

	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 El 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.