

**Product and Test Requisition Form: HLA MATCHED/CROSSMATCHED PLATELETS and
PLATELET ANTIBODY SCREENING (HLA and Platelet Specific)**

Hospital: _____ **Phone#:** _____ **Fax#:** _____

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

Patient Information (Complete):

Name (Last, First)	Date of Birth	Medical Record Number	ABO/ Rh Type
Current Platelet Count: _____ Date: _____ Active bleeding: <input type="checkbox"/> Yes <input type="checkbox"/> No Site: _____ <i>(If Applicable)</i>			
Transfusions History: # of Platelet Transfusions: _____ Most recent dates(s): _____			
Prior HLA/Platelet Antibody Screen: <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____ Results _____			
CLINICAL INFORMATION: Are there other factors contributing to platelet refractoriness? (check all that apply): <input type="checkbox"/> Fever <input type="checkbox"/> Infection <input type="checkbox"/> Patient on anti-fungal therapy <input type="checkbox"/> Enlarged spleen <input type="checkbox"/> Evidence of DIC			

Products Requested (Indicate with an X):

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 (Provide patient's HLA typing) PATIENT HLA TYPING: _____ <i>(Document and fax patient's HLA Typing)</i>
ADDITIONAL PRODUCT REQUIREMENTS:	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: _____ <i>(Indicate)</i>
# of Units Requested: _____ Units Needed By: _____	

Testing Requested (Patient Sample Required; Indicate with an X):

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

Community Blood Services (CBS) Staff (Complete as Applicable):

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

Reference Laboratory: Phone #: 201-251-3975 Fax: 201-670-6174 CLIA #31D0112691

Note: Ship samples at room temperature. Plasma should be separated from the red cells if not shipped immediately. Samples must be received less than 48 hrs post collection for testing, 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. A new patient specimen is required every 7 days.

**Instructions for: Product and Test Requisition Form: HLA MATCHED/CROSSMATCHED PLATELETS and
PLATELET ANTIBODY SCREENING (HLA and Platelet Specific)**

Hospital: Client shall enter Hospital Information **Phone#:** Client phone number **Fax#:** Client fax number

Requested: Date: Enter request of service date **Time:** Enter request time of service **Requested By (Hospital Staff):** Requesting Staff to enter Initials

Patient Information (Complete):

Name (Last, First)	Date of Birth	Medical Record Number	ABO/ Rh Type
<i>Enter patient's Last, First name</i>	<i>Enter patient's Date of Birth</i>	<i>Enter patient's Medical Record Number or Applicable</i>	<i>Enter patient's ABO/Rh Typing</i>
<p><i>Client Shall Complete the Following Patient Information:</i></p> <p>Current Platelet Count: _____ Date: _____ Active bleeding: <input type="checkbox"/> Yes <input type="checkbox"/> No Site: _____ (If Applicable)</p> <p>Transfusions History: # of Platelet Transfusions: _____ Most recent dates(s): _____</p> <p>Prior HLA/Platelet Antibody Screen: <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____ Results _____</p> <p>CLINICAL INFORMATION: Are there other factors contributing to platelet refractoriness? (check all that apply): <input type="checkbox"/> Fever <input type="checkbox"/> Infection <input type="checkbox"/> Patient on anti-fungal therapy <input type="checkbox"/> Enlarged spleen <input type="checkbox"/> Evidence of DIC</p>			

Client Shall Complete the Following Requesting Information:

Products Requested (Indicate with an X):

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 (Provide patient's HLA typing) PATIENT HLA TYPING: _____ <i>(Document and fax patient's HLA Typing)</i>
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: _____ <i>(Indicate)</i>
<i>Client Shall Complete the Following Requesting Information:</i> <div style="text-align: right;"># of Units Requested: _____ Units Needed By: _____</div>	

Client Shall Complete the Following Requesting Information:

Testing Requested (Patient Sample Required; Indicate with an X):

Indicate with an X <i>(If applicable)</i> <input type="checkbox"/> Platelet Antibody Screen (HLA and platelet specific)	Indicate with an X <i>(If applicable)</i> <input type="checkbox"/> Platelet Antibody Identification (I.D.)
Indicate: Sample ID <u>Enter Sample ID.</u> Collection Date <u>Enter Collection Date</u> Collection Time: <u>Enter time sample was collected</u> <i>Mark type of tubes sent and number of each type</i>	
Sample Type (indicate # of tubes): <input type="checkbox"/> EDTA Plasma _____ <input type="checkbox"/> Serum _____ <input type="checkbox"/> Other _____ <i>(if Applicable)</i> Minimum: 1 x 7mL EDTA plasma or serum for Each Assay.	

Community Blood Service's Staff Complete the Following:

Community Blood Services (CBS) Staff (Complete as Applicable):

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