COMMUNITY BLOOD SERVICES
102 Chestnut Ridge Road, Montvale, NJ 07645

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
				☐ Male ☐ Female

Current Platelet Count: _____x 10^{11} **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 an X)*

PRODUCT REQUESTED:	☐ **Cross Matched Platelets (Patient Sample Required)** **Minimum: 1 x 7mL EDTA plasma or serum**
	☐ **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: ☐ Yes ☐ No CMV Neg: ☐ Yes ☐ No Irradiated: ☐ Yes ☐ No** **Other: _____ *(Indicate)***
# of Units Requested:_____ Units Needed By:_____	

Testing Requested *(Indicate by an X, Patient Sample Required)*

☐ **Platelet Antibody Screen**	☐ **Platelet Antibody Identification (I.D.)**

If Applicable: Sample ID: _____ Collection Date: _____ Collection Time: _____
Sample Type (indicate # of tubes): ☐ EDTA Plasma _____ ☐ Serum _____ ☐ Other _____*(if Applicable)*
Minimum: 1 x 7mL EDTA plasma or serum for Each Assay.

Community Blood Services (CBS) Staff Notified

Information Received By:_____	**Date/Time:_____**
Sample Received By: _____ Date/Time:_____	
Sample Integrity: ☐ Acceptable ☐ Unacceptable Comments:_____	

Reference/Tech. Services Laboratory: Phone #: _____ Fax: _____

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.