Community Blood Center Administrative Offices: 4040 Main Street Kansas City, Missouri 64111
Phone: 816-968-4053 **Fax: 816-277-0757**

IMMUNOHEMATOLOGY LABORATORY
HLA MATCHED PLATELET REQUEST FORM

Patient's Name/ID _____ Birth Date _____

Patient CMV Status: Negative ☐ Positive ☐ Unknown ☐ 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: