*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 7-10 mL ACD Whole Blood or 2 mL ACD plasma

☐ 3980 **Platelet Antibody Screen using ELISA Assay – PakPlus**
Requires 7 mL ACD Whole Blood or 2 mL ACD plasma **AND** 7-10 mL clotted whole blood or 2 mL serum

☐ 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:_____
Are Non ABO type-specific platelets Acceptable? Yes:_____ No:_____

☐ 3983 Investigate Neonatal Immune Thrombocytopenia
Requires 14-20 mL **Maternal** ACD whole blood, < 24 hours, unrefrigerated **AND** 7-10 mL clotted whole blood or 2 mL serum if PakPlus testing needed
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 **AND** 7-10 mL clotted whole blood or 2 mL serum if PakPlus testing needed. 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
Capture P: Neg_____ Pos _____

	Date Tested	Number Tested	Number Compatible
Ready P: Neg_____ Pos _____			
PBIgG: Neg_____ Pos_____			
PAKPlus: Neg _____ Pos _____	TOTAL		

Comments:_____

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.