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**

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| --- |
| **For CBC Use Only** |
| Billing Entered into El Dorado By: Date: |