



Testing Request

Platelet Antibody Screen / Cross-Matched Platelets

Form and Specimen Instructions	Fax completed form to 516-478-5567					
	Label all specimens clearly- Last name, first name, date of birth, date drawn					
	1	Specimen requirements: (2) tubes Whole Blood (no gel) or 4 mL serum/plasma. Acceptable anti-coagulants are EDTA, ACD, CPD or CPDA-1. Samples should be transported with ICE or cold packs and MUST be less than 48 hours old when received for testing.				
	2	For specimen pick-up: Contact Client Services Department at: 855-552-5663 or 718-707-3771				
3	Send specimens with a copy of this form to: Westbury – QC/Reference Laboratory, 1200 Prospect Avenue, Westbury, NY 11590 Main Phone #: (516) 478-5160					
Hospital Information	Hospital name:				Date:	
	Street Address:			City:	State:	Zip:
	Contact Person name:		Blood bank phone:		Fax number:	
Patient Information	Last name:		First name:		DOB:	MRN:
	Gender		Blood Type		CMV Status	
	<input type="checkbox"/> Male		ABO:		<input type="checkbox"/> Negative	
	<input type="checkbox"/> Female		Rh:		<input type="checkbox"/> Positive	
					<input type="checkbox"/> Unknown	
				Current Platelet Count		
				Number: _____		
				Date: _____		
		Diagnosis:				
Sample Info	Collection Date of Sample sent - _____					or <input type="checkbox"/> No Sample sent
Request Details	Requested Test		Cross Matched Platelet Request		Restrict to types:	
	<input type="checkbox"/> Platelet Antibody Screen		<input type="checkbox"/> Non-Type Specific acceptable		<input type="checkbox"/> A	
	<input type="checkbox"/> Additional Sample for Future Testing		If not acceptable , complete next columns		<input type="checkbox"/> AB <input type="checkbox"/> Rh+	
				<input type="checkbox"/> B <input type="checkbox"/> Rh-		
				<input type="checkbox"/> O		
Product Delivery	<input type="checkbox"/> STAT		Special Requirements		<input type="checkbox"/> CMV Negative	
	<input type="checkbox"/> ASAP				<input type="checkbox"/> Irradiated	
	<input type="checkbox"/> ROUTINE				<input type="checkbox"/> Other (describe): _____	
Date(s) of Transfusion is required to supply product with useable expiration date:						
Enter each date of transfusion:						
Amount requested per transfusion:						
QC Reference Use ONLY Specimen Details	Received date/time:		Received by (name):		Condition	
					<input type="checkbox"/> Acceptable <input type="checkbox"/> Unacceptable	
	Comments:					