New York Blood Center

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	Current Platelet Count
☐ Male	ABO:	☐ Negative	Number:
☐ Female	Rh:	☐ Positive	Date:
		☐ Unknown	

Diagnosis:

Sample Info — **Collection Date of Sample sent -** **or** ☐ **No Sample sent**

Request Details	Requested Test	Cross Matched Platelet Request	Restrict to types:
	☐ Platelet Antibody Screen	☐ Non-Type Specific acceptable	☐ A; ☐ AB ☐ Rh+; ☐ B ☐ Rh-; ☐ O
	☐ Additional Sample for Future Testing	If **not acceptable**, complete next columns →	

Product Delivery	☐ STAT ☐ ASAP ☐ ROUTINE	**Special Requirements**	☐ CMV Negative ☐ Irradiated ☐ 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**
			☐ Acceptable ☐ Unacceptable
	Comments:		