

American Red Cross
North Central Blood Services
100 South Robert Street
St. Paul, MN 55107
651-291-6797 / 800-652-9742
FAX: 651-291-3233

SAMPLE RECEIVED:		
Date _____	Time _____	Initials _____
Temp upon receipt _____	Temp stored at _____	

REQUEST FOR PLATELET TESTING

I. PATIENT INFORMATION

* Name: _____	* Patient ID #: _____
* Birthdate: _____	* Date of Specimen: _____
* Institution: _____	* Gender (<i>circle one</i>): M or F
City/State: _____	* Physician: _____
Contact: _____	Phone Number: _____

* **Required**

II. TESTING REQUESTED

<input type="checkbox"/> Platelet Crossmatch	<input type="checkbox"/> Platelet Crossmatch Incompatibility Screen
<input type="checkbox"/> Platelet Antibody Screen	<input type="checkbox"/> Platelet Associated Ig
<input type="checkbox"/> Heparin Antibody Test (HAT)	<input type="checkbox"/> HPA-1a (P1 ^{A1}) Antigen Typing
<input type="checkbox"/> Other: _____	

III. PRODUCT REQUIREMENTS (*Only fill out when ordering Platelet Crossmatch*)

* Patient's ABO/Rh type: _____	Special Requirements:
Platelet ABO/Rh type: _____ (option #1)	<input type="checkbox"/> CMV Negative
_____ (option #2)	<input type="checkbox"/> Irradiated
_____ (option #3)	<input type="checkbox"/> Other: _____

* **Required**

Number of Apheresis Products Requested: _____ When: _____

IV. COMMENTS _____

V. REPORTS

Do you wish to have the report mailed? or faxed? FAX number: _____

NOTE: See reverse side for specimen requirements.

REQUEST FOR PLATELET TESTING

- INSTRUCTIONS FOR SUBMISSION OF SAMPLE -

- Contact the Platelet Serology Laboratory by calling (651) 291-6797 during routine hours, Monday through Friday, 8:00 AM to 4:30 PM **OR** the Reference Laboratory at (651) 291-6760 Monday through Friday 4:30 PM to Midnight.

During non-routine hours: Monday thru Friday, Midnight to 8:00 AM
(Crossmatch only) Weekends and Holidays, Contact the Reference Technologist on call through Hospital Services at (651) 291-6767.

- Specimen Requirements:

TEST	SAMPLE REQUIREMENTS	SHIPPING
Platelet Crossmatch/Platelet Crossmatch Incompatibility Screen	<ul style="list-style-type: none"> • Plasma (EDTA, ACD, CPD, CPDA-1) • Separate plasma from red cells. • Refrigerate for no longer than 48 hrs. after collection. • After 48 hours freeze specimen. <p><i>Maximum number of days a sample can be used for testing is 7 days.</i></p>	<p>Send on wet ice/cold pack within 48 hr.</p> <p>Send on dry ice after 48 hr. of collection.</p>
Platelet Antibody Screen (Indirect)	<ul style="list-style-type: none"> • Serum or Plasma (ACD or EDTA) • Separate plasma/serum from red cells. • Refrigerate for no longer than 48 hrs. after collection. • After 48 hours freeze specimen. 	<p>Send on wet ice/cold pack within 48 hr.</p> <p>Send on dry ice after 48 hr. of collection</p>
Platelet Associated Ig (Direct)	<ul style="list-style-type: none"> • Send EDTA tubes (minimum 20 mL) (DO NOT SEPARATE) 	Send at Room Temperature
Heparin Antibody Test (HAT)	<ul style="list-style-type: none"> • Serum ONLY • Separate serum from red cells. • Refrigerate for no longer than 48 hrs. after collection. • After 48 hours freeze specimen. 	<p>Send on wet ice/cold pack within 48 hr.</p> <p>Send on dry ice after 48 hr. of collection.</p>
HPA-1a (Pl ^{A1}) Antigen Typing	<ul style="list-style-type: none"> • Plasma (EDTA) 5-7 mL (DO NOT SEPARATE) 	<p>Needs to arrive at our lab within 48 hours of draw.</p> <p>Send at Room Temperature</p>

- All blood specimens **MUST** be labeled with the patient's full name, date collected, and secondary identification # **OR** date of birth.
- Specimens should be shipped in accordance with federal and local requirements for transporting diagnostic specimens.
- At a minimum, complete the required sections of the "Request for Platelet Testing" form.
- Return the completed "Request for Platelet Testing" form along with the specimen.
- Place a mailing label on the outer container with the following information:

American Red Cross - North Central Blood Services
100 South Robert Street
St. Paul, MN 55107
ATTN: Platelet Serology Laboratory