New York Blood Center

Testing Request Form
Platelet Antibody Screen / Cross-Matched Platelets

Platelet Antibody Screening and/or Cross Matched Platelet orders - FAX Form to (516) 478-5567

Please send specimens with a copy of this form to:

Westbury – QC/Reference Laboratory, 1200 Prospect Avenue, Westbury, NY 11590
Main Phone #: (516) 478-5160

Label all specimens clearly - Last name, first name - DOB - 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**

Hospital:_____ Date:_____

Address:_____ City:_____ State:_____ Zip:_____

Contact Person: _____

Blood Bank Phone #_____ Fax # _____

Patient Information

Last Name: _____ **First Name:** _____ **MRN:**_____

DOB:_____ **Male**☐ **Female**☐ **Blood Type:** ABO____ Rh____ **CMV Status:** Neg☐ Pos☐ Unknown☐

Diagnosis:_____

Current Platelet Count:_____ Date:_____

Testing Requested: Platelet Antibody Screen ☐ Additional Sample for Future Testing ☐

Cross matched Platelet Request:
Non-Type Specific Acceptable ☐ or Restrict to Types (please check)

A	AB	B	O
☐	☐	☐	☐

***Special Requirements*: CMV Neg** ☐ **Irradiated** ☐ Other:_____

Date(s) of Transfusion is required to supply product with useable expiration date.							
Enter each date(s) of transfusion							
Amount requested per transfusion							

Product Delivery: STAT ☐ ASAP ☐ Routine ☐

QC/Reference Lab Use Only

Specimen Received - Date/Time:_____ Received by:_____

Condition of Specimen: Acceptable:____ Unacceptable:_____

Comments:_____