

Versiti does NOT bill patients or their insurance. Test orders must be placed through a medical facility that has an account with Versiti. Client # required.



**Platelet and Neutrophil Immunology Laboratory**  
Phone 800-245-3117 x 6250 / Fax (414) 937-6245

Person Completing Requisition:	
Institution:	Client#
Dept:	Physician/Provider:
Address:	
City:	ST: ZIP:
Phone (Lab):	Phone/Email (Provider):

Is testing for outpatient Medicare enrollee or Wisconsin Medicaid recipient? \*Yes No

\*If YES, please complete the **beneficiary form** located at [www.versiti.org/medical-professionals/products-services/requisitions](http://www.versiti.org/medical-professionals/products-services/requisitions) and submit with this requisition.

Special Reporting Requests:	PO#:
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**PATIENT INFORMATION**

Last Name:	First Name:	MI:	DOB:
MR#:	Accession#:	Draw Date:	Draw Time:
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Is patient pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Due / Delivery date: _____		
Has patient had an allogeneic stem cell transplant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, send pre-transplant extracted DNA sample	Has patient had a blood transfusion in the last 2 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No Date and type of transfusion: _____		

Specimen Type: <input type="checkbox"/> ACD-A Blood <input type="checkbox"/> ACD-B Blood <input type="checkbox"/> Citrated Plasm <input type="checkbox"/> EDTA Blood <input type="checkbox"/> Serum (red top) <input type="checkbox"/> Serum (SST tube) <input type="checkbox"/> Buccal Swabs
Fetal Specimen Type: <input type="checkbox"/> Amniotic Fluid <input type="checkbox"/> Cultured Amniocytes <input type="checkbox"/> CVS <input type="checkbox"/> Cultured CVS <input type="checkbox"/> Cord Blood <input type="checkbox"/> DNA

Diagnosis \_\_\_\_\_ Number of Pregnancies \_\_\_\_\_ Platelet Count \_\_\_\_\_ Neonate's Platelet Count \_\_\_\_\_  
Number of Platelet Transfusions \_\_\_\_\_ Neutrophil Count \_\_\_\_\_ Neonate's Neutrophil Count \_\_\_\_\_

**TEST ORDERS** (See reverse side for sample requirements and panel details)

**Immune Thrombocytopenias**

<b>Drug-Induced Thrombocytopenia (non-heparin)</b> <input type="checkbox"/> Drug Dependent Platelet Antibody (9000) To prevent delays in testing, please list drugs to be tested (attach list if needed): _____	<b>Immune Thrombocytopenia (ITP)</b> <input type="checkbox"/> Platelet Autoantibodies (5544) (Sample must be received within 4 days of draw. See Whole Blood Age Table on page 2.)
<b>Heparin-Induced Thrombocytopenia</b> <input type="checkbox"/> Heparin Dependent Platelet Antibody IgG PF4 ELISA (5510) <input type="checkbox"/> Heparin Dependent Platelet Antibody IgA and IgM PF4 ELISA (5514) <input type="checkbox"/> Heparin-Induced Thrombocytopenia – SRA (5508) <input type="checkbox"/> Heparin-Induced Thrombocytopenia – PEA (5502) <input type="checkbox"/> Heparin-Induced Thrombocytopenia Evaluation – SRA (5509) (test 5510 REFLEX to SRA) <input type="checkbox"/> Heparin-Induced Thrombocytopenia Evaluation – PEA (5504) (test 5510 REFLEX to PEA)	<b>Neonatal Alloimmune Thrombocytopenia (NAIT)</b> <input type="checkbox"/> Initial testing of Maternal sample with Paternal samples (5603/5703) Father's Name _____ Date of Birth _____ <input type="checkbox"/> Initial testing of Maternal sample ONLY (5303) <b>Follow up NAIT testing</b> (Order only after 5603 or 5303 have been completed or as advised by BCW) <input type="checkbox"/> Serial Monitoring of Maternal sample with Paternal Crossmatching (5640) Father's Name _____ Date of Birth _____ <input type="checkbox"/> Serial Monitoring of Maternal sample ONLY (5630)
<b>Alloimmune Thrombocytopenia</b> <input type="checkbox"/> Platelet Antibody Screen (5543) <input type="checkbox"/> Platelet Antibody Identification Panel (5608) (Includes the Platelet Antibody Screen. Detects antibodies to HPA-1, -2, -3, -4, -5, GPIIb/IIIa, GPIa/IIa, GPIb/IX, GPIV, and Class I HLA)	<b>Transfusion Medicine Complications</b> <input type="checkbox"/> Platelet Transfusion Refractory (PTR) Panel (5632) <input type="checkbox"/> Post-Transfusion Purpura (PTP) Panel (5631) (Each panel includes the Platelet Antibody Identification Panel and the Platelet Antigen Genotyping Panel)

**Immune Neutropenias**

<b>Alloimmune Neutropenia</b> <input type="checkbox"/> Neutrophil Antibody Screen (5102) <input type="checkbox"/> Neutrophil Antibody Screen with REFLEX to HLA Antibody Screen (5110) <input type="checkbox"/> Neutrophil Antibody Screen with REFLEX to 5113 (5119) <input type="checkbox"/> Neutrophil Antibody Screen and HLA Antibody Screen (5112) <input type="checkbox"/> Neutrophil Antibody Identification and HLA Antibody Screen (5113)	<b>Transfusion Related Acute Lung Injury (TRALI)</b> <input type="checkbox"/> TRALI Workup on Donor serum (5112) Recipient Name: _____ <input type="checkbox"/> TRALI Workup on Recipient/Patient serum (5112): Name(s) or unit #(s) of Donors: _____ <input type="checkbox"/> HOLD TRALI Recipient (5002) Name(s) or unit #(s) of donors: _____
<b>Drug-Induced Neutropenia</b> <input type="checkbox"/> Drug Dependent Neutrophil Antibody (9500) List drugs to be tested: (attach list if needed) _____	<b>Neonatal Alloimmune Neutropenia</b> <input type="checkbox"/> Neonatal Alloimmune Neutropenia (NAN) (5125/5126) Father's Name _____ Date of Birth _____

**Genotyping**

<b>Platelet Antigen Genotyping</b> (testing for parental/patient/fetal samples) <input type="checkbox"/> Panel (5600) (HPA-1, HPA-2, HPA-3, HPA-4, HPA-5, HPA-6, HPA-9, HPA -15) OR <input type="checkbox"/> HPA-1 (5519) <input type="checkbox"/> HPA-2 (5523) <input type="checkbox"/> HPA-3 (5520) <input type="checkbox"/> HPA-4 (5521) <input type="checkbox"/> HPA-5 (5522) <input type="checkbox"/> HPA-6 (5524) <input type="checkbox"/> HPA-9 (5209) <input type="checkbox"/> HPA-15 (5215)	<b>Neutrophil Antigen Genotyping</b> (testing for parental/patient/fetal samples) <input type="checkbox"/> Panel (5201) (HNA-1, HNA-3, HNA-4, HNA- 5) OR <input type="checkbox"/> HNA-1 (5250) <input type="checkbox"/> HNA-3 (5203) <input type="checkbox"/> HNA-4 (5204) <input type="checkbox"/> HNA-5 (5205)
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**Immunophenotyping**

<b>Glanzmann Thrombasthenia or Bernard Soulier Syndrome</b> <input type="checkbox"/> Platelet Glycoprotein Expression (PGE) (5545)	<b>Paroxysmal Nocturnal Hemoglobinuria (PNH)</b> <input type="checkbox"/> PNH - Leukocytes (5549) <input type="checkbox"/> PNH – Erythrocytes & Leukocytes (5550)	<b>VERSITI USE ONLY</b> EDTA _____ Serum _____ Amnio _____ ACDA _____ ACDB _____ Clot _____ Other _____ Opened By _____ Evaluated By _____
<b>Other</b> <input type="checkbox"/> Glycoprotein IV (CD36) Typing (5444)		

**SAMPLE REQUIREMENTS AND SHIPPING INSTRUCTIONS** *Label samples clearly with full name of individual, date and time drawn.*

Test	Sample Requirement									
Drug Dependent Platelet Antibody Drug Dependent Neutrophil Antibody Heparin-Induced Thrombocytopenia Evaluation (SRA) Heparin Dependent Platelet Antibody (PF4 ELISA) (IgG, IgA and IgM) Heparin-Induced Thrombocytopenia (SRA) NAIT <b>Serial</b> Monitoring of Maternal sample ONLY Neutrophil Antibody Screen (5102, 5110, & 5119) Neutrophil Antibody Screen and HLA Antibody Screen Neutrophil Antibody Identification and HLA Antibody Screen Platelet Antibody Screen Flow Cytometry Platelet Antibody Identification Panel	5 ml of serum per test ordered. Sample must be less than 7 days old when tested. Store refrigerated. <b>Send sample refrigerated.</b> (If the sample has been kept frozen it may be more than 7 days old.) <b>Send frozen samples on dry ice.</b>									
Heparin-Induced Thrombocytopenia (PEA) Heparin-Induced Thrombocytopenia Evaluation (PEA)	5 ml serum collected at least 3 hours after heparin administration. Minimum/Pediatric volume: 1mL. Plasma is NOT acceptable for this assay. Sample must be less than 7 days old when tested. Store refrigerated. <b>Send sample refrigerated.</b> (If the sample has been kept frozen it may be more than 7 days old.) <b>Send frozen samples on dry ice.</b> Room temperature samples are not acceptable.									
Platelet Glycoprotein Expression (PGE)	5 ml ACD-B or ACD-A whole blood from patient and a control from a volunteer donor unrelated to patient. <b>Sample must be less than 2 days old when received. Send FedEx Priority Overnight Mon – Thurs. Send refrigerated.</b>									
Platelet Autoantibodies	40 ml ACD-A whole blood if patient platelet count <100,000. 10 ml ACD-A whole blood if patient platelet count >100,000. <b>See Whole Blood Age Table for draw date and received date requirements. Send sample refrigerated.</b>									
Paroxysmal Nocturnal Hemoglobinuria PNH – Leukocytes PNH – Erythrocytes & Leukocytes	5 ml EDTA whole blood. <b>Sample must be less than 2 days old when received. Send FedEx Priority Overnight Monday – Thursday. Send sample refrigerated.</b>									
Glycoprotein IV (CD36 Typing)	10 ml ACD-A or EDTA whole blood. <b>Send sample at room temperature</b>									
TRALI Donor (Transfusion Related Acute Lung Injury) TRALI Recipient (Transfusion Related Acute Lung Injury)	5 ml serum and 5 ml EDTA whole blood. <b>Send sample refrigerated. Links/segments are not acceptable</b>									
<b>HOLD</b> TRALI Recipient (Transfusion Related Acute Lung Injury) (Sample will be held for 2 months in the event that HLA or Neutrophil Typing is wanted. <b>Client is responsible for placing the typing order.</b> )	5 ml EDTA whole blood. <b>Send sample refrigerated. Links/segments are not acceptable</b>									
Neutrophil Antigen Genotyping - Individual or Panel Platelet Antigen Genotyping - Individual or Panel	3-5 ml EDTA whole blood 7-15 ml amniotic fluid 5 x 10 <sup>6</sup> cultured amniotic cells 1 ml Cord Blood 1µg DNA (25ng/µl and 25µl) 3-4 Buccal Swabs <b>Send sample at room temperature or refrigerated.</b>									
Neonatal Alloimmune Thrombocytopenia (NAIT or NATP) <b>Initial testing on Maternal sample with Paternal sample</b> (Includes Platelet Antigen Genotyping Panel of mother and father and Platelet Antibody Identification Panel of mother including crossmatches) <b>Serial Monitoring testing on Maternal and Paternal samples</b> (Includes Platelet Antibody Identification Panel of mother including crossmatches of mother's serum against father's platelets)	<table border="1"> <thead> <tr> <th></th> <th>Initial</th> <th>Serial Monitoring</th> </tr> </thead> <tbody> <tr> <td>Mother</td> <td>30 ml ACD-A whole blood and 10 ml serum</td> <td>10 ml serum</td> </tr> <tr> <td>Father</td> <td>30-40 ml ACD-A whole blood</td> <td>30-40 ml ACD-A whole blood</td> </tr> </tbody> </table> <p><b>Each sample must be clearly labeled with the full name of individual (mother or father). See Whole Blood Age Table. Send sample refrigerated.</b></p>		Initial	Serial Monitoring	Mother	30 ml ACD-A whole blood and 10 ml serum	10 ml serum	Father	30-40 ml ACD-A whole blood	30-40 ml ACD-A whole blood
	Initial	Serial Monitoring								
Mother	30 ml ACD-A whole blood and 10 ml serum	10 ml serum								
Father	30-40 ml ACD-A whole blood	30-40 ml ACD-A whole blood								
Neonatal Alloimmune Thrombocytopenia (NAIT or NATP) <b>Initial testing on Only Maternal sample</b> (Includes Platelet Antigen Genotyping Panel of mother and Platelet Antibody Identification Panel of mother)	30 ml ACD-A whole blood from mother 10 ml serum from mother <b>See Whole Blood Age Table for draw date and received date requirements. Send sample refrigerated.</b>									
Post-Transfusion Purpura (PTP) Platelet Transfusion Refractory (PTR)	5-10 ml EDTA whole blood 10 ml serum <b>Send sample refrigerated.</b>									
Neonatal Alloimmune Neutropenia (NAN) (Includes Neutrophil Antibody Identification and HLA Antibody Screen on Mother and Neutrophil Antigen Genotyping Panel of Mother and Father)	5-10 ml EDTA whole blood from mother and father 5-10 ml serum from mother <b>Send sample refrigerated.</b>									
<b>Whole Blood Age Table</b>										
Sample drawn on	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday			
Must be received by	Friday	Friday	Friday	Monday	Tuesday	Wednesday	Thursday			

**SHIPPING INFORMATION**

Ship all samples according to catalog description by Next Day delivery unless specified differently above. If refrigeration is required, use sealed ice packs or wet ice sealed in plastic bags. **Protect whole blood samples from freezing by wrapping in paper toweling.** Mark box **Refrigerate Upon Arrival.** The package must be shipped in compliance with carrier's guidelines. Please contact your carrier for current biohazard shipping regulations.

*Please call Versiti Client Services (800-245-3117 ext 6255) for advice if you will ship samples near a major holiday.*

Shipping Address: **Versiti Diagnostic Laboratories / Client Services**  
638 North 18<sup>th</sup> Street  
Milwaukee, WI 53233-2121