

Versiti does NOT bill patients or their insurance. Call 800-245-3117 ext. 6250 for your Client#.

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



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

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 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 Plasma <input type="checkbox"/> EDTA Blood <input type="checkbox"/> Serum (red top) <input type="checkbox"/> Serum (SST tube)
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						
Drug-Induced Thrombocytopenia (non-heparin) <input type="checkbox"/> Drug Dependent Platelet Antibody (9000) To prevent delays in testing, please list drugs to be tested (attach list if needed): _____ _____ _____	Immune Thrombocytopenia (ITP) <input type="checkbox"/> Platelet Autoantibodies (5544) (Sample must be received within 4 days of draw. See Whole Blood Age Table on page 2.) Neonatal Alloimmune Thrombocytopenia (NAIT) <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) Follow up NAIT testing (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)					
Heparin-Induced Thrombocytopenia <input type="checkbox"/> Heparin-Induced Thrombocytopenia Evaluation (5509) (test 5510 REFLEX to 5508) <input type="checkbox"/> Heparin Dependent Platelet Antibody IgG PF4 ELISA (5510) <input type="checkbox"/> STAT, local customers only. Please call 800-245-3117 ext 6250 <input type="checkbox"/> Heparin Dependent Platelet Antibody IgA and IgM PF4 ELISA (5514) <input type="checkbox"/> Heparin Dependent Platelet Antibody Serotonin Release Assay (5508)	Transfusion Medicine Complications <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)					
Alloimmune Thrombocytopenia <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)	Immune Neutropenias					
Alloimmune Neutropenia <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)	Transfusion Related Acute Lung Injury (TRALI) <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: _____					
Drug-Induced Neutropenia <input type="checkbox"/> Drug Dependent Neutrophil Antibody (9500) List drugs to be tested: (attach list if needed) _____	Neonatal Alloimmune Neutropenia <input type="checkbox"/> Neonatal Alloimmune Neutropenia (NAN) (5125/5126) Father's Name _____ Date of Birth _____					
Genotyping						
Platelet Antigen Genotyping (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)	Neutrophil Antigen Genotyping (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)					
Immunophenotyping						
Glanzmann Thrombasthenia or Bernard Soulier Syndrome <input type="checkbox"/> Platelet Glycoprotein Expression (PGE) (5545)	Paroxysmal Nocturnal Hemoglobinuria (PNH) <input type="checkbox"/> PNH - Leukocytes (5549) <input type="checkbox"/> PNH - Erythrocytes & Leukocytes (5550)					
Other <input type="checkbox"/> Glycoprotein IV (CD36) Typing (5444)	VERSITI USE ONLY <table border="1"> <tr> <td>EDTA _____ Serum _____</td> <td rowspan="4">Opened By _____ Evaluated By _____</td> </tr> <tr> <td>Amnio _____ ACDA _____</td> </tr> <tr> <td>ACDB _____ Clot _____</td> </tr> <tr> <td>Other _____</td> </tr> </table>	EDTA _____ Serum _____	Opened By _____ Evaluated By _____	Amnio _____ ACDA _____	ACDB _____ Clot _____	Other _____
EDTA _____ Serum _____	Opened By _____ Evaluated By _____					
Amnio _____ ACDA _____						
ACDB _____ Clot _____						
Other _____						

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 Heparin Dependent Platelet Antibody (PF4 ELISA) (IgG, IgA and IgM) Heparin Dependent Platelet Antibody Serotonin Release Assay NAIT Serial 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. (If the sample has been kept frozen it may be more than 7 days old.) Send sample refrigerated.									
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. Sample must be less than 2 days old when received. Send FedEx Priority Overnight Monday – Thursday.									
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. See Whole Blood Age Table for draw date and received date requirements. Send sample refrigerated.									
Paroxysmal Nocturnal Hemoglobinuria PNH – Leukocytes PNH – Erythrocytes & Leukocytes	5 ml EDTA whole blood. Send sample refrigerated. Sample must be less than 2 days old when received. Send FedEx Priority Overnight Monday – Thursday.									
Glycoprotein IV (CD36 Typing)	10 ml ACD-A or EDTA whole blood. Send sample at room temperature									
TRALI Donor (Transfusion Related Acute Lung Injury) TRALI Recipient (Transfusion Related Acute Lung Injury)	5 ml serum and 5 ml EDTA whole blood. Send sample refrigerated. Links/segments are not acceptable									
HOLD TRALI Recipient (Transfusion Related Acute Lung Injury) (Sample will be held for 2 months in the event that HLA or Neutrophil Typing is wanted. Client is responsible for placing the typing order.)	5 ml EDTA whole blood. Send sample refrigerated. Links/segments are not acceptable									
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 ⁶ cultured amniotic cells 1 ml Cord Blood 1µg DNA (25ng/µl and 25µl) Send sample at room temperature or refrigerated.									
Neonatal Alloimmune Thrombocytopenia (NAIT or NATP) Initial testing on Maternal sample with Paternal sample (Includes Platelet Antigen Genotyping Panel of mother and father and Platelet Antibody Identification Panel of mother including crossmatches) Serial Monitoring testing on Maternal and Paternal samples (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>Each sample must be clearly labeled with the full name of individual (mother or father). See Whole Blood Age Table. Send sample refrigerated.</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) Initial testing on Only Maternal sample (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 See Whole Blood Age Table for draw date and received date requirements. Send sample refrigerated.									
Post-Transfusion Purpura (PTP) Platelet Transfusion Refractory (PTR)	5-10 ml EDTA whole blood 10 ml serum Send sample refrigerated.									
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 Send sample refrigerated.									
Whole Blood Age Table										
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 the laboratory (800-245-3117 ext 6255) for advice if you will ship samples near a major holiday.

Shipping Address: **Versiti Wisconsin – Platelet & Neutrophil Laboratory**
638 North 18th Street
Milwaukee, WI 53233-2121