

Versiti Michigan, Inc.

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HLA LABORATORY

SPECIAL ORDER APHERESIS PLATELETS REQUEST CLIA ID # 23D0724117

ALL FOLLOWING IN	FORMATION IS REQUIRED:		Date of Request		
			Date of Request Date Product(s) Requested for:		
			. , .		
	: Irradiation of HLA-matched apheresis is	s required.	1)		
	/ NECATIVE products requested	:	2)		
	/ NEGATIVE products requested: Should be consistent with other transfus	sed products.	3)		
Insert Hospital Lab	el for Patient or complete:	Hospital:			
Name:		ABO/Rh:	CMV sta	tus:	
D.O.B:			Antibodies:		
Medical Record #: _		PRA:			
Weight: Race: Sex: M					
Attending Physician: Phone:					
			Phone:		
(Complete below for HLA-matched products only)					
Clinical History:					
Diagnosis:		When diagnosed:			
Chemotherapy:		Expected duration of cytopenia:			
# Chemotherapy Courses:		Date Completed:			
Is patient in remission?		Is patient possible BMT?			
Stem Cell Transplant Date:		Is patient engrafted?			
Patient is taking: (check all that apply)					
☐ Quinine		- Which?			
☐ Quinidine					
☐ Amphotericin B	☐ Heparin				
Clinical Condition: (check all that apply)					
□ Splenomegaly □ Infection – Location:					
☐ Post-Splenectomy	□ Bleeding – Location:				
	□ Sepsis – Blood Cultures/Date:				
□ Petechiae	☐ Hepatomegaly				
Transfusion History:					
Date	Platelet Count	(Check on		WBC Count	
		□ 1 hr / □ 24 hr /			
		□ 1 hr / □ 24 hr /			
		□ 1 hr / □ 24 hr .			

□ 1 hr / □ 24 hr / □ other