

Patient surname

Estimated ongoing platelet requirements

HLA

Selected

If "Yes", would they administer anti-D immunoglobulin?

Please tick all that

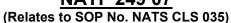
apply

doctor/CCS Signature

Authorising SNBTS CD

NATF 249 07

Patient forename





Initial Request for HLA/HPA Selected Platelets

All parts of this form should be completed by SNBTS medical staff

Part 1: Pre-testing discussion Sample requirements are 5ml EDTA (HLA/HPA typing) and 10ml clotted (HLA/HPA antibodies)

Date of birth				Hosp	oital/C	НΙΝ	Number			
Gender					ıht (ap					
Blood group					′ statu		,			
Hospital	-				Consultant					
Ward					Contact details					
Disease and remission statu	ıs			1 00			-			
Current therapy				Current platelet of						
Has the patient had an allo	HSC trans	splant? – Spe	ecify da	ate & m	atch o	grad	le eg haplo, 10	0/10		
Information on previous plat transfusions and increments	telet				•					
Splenomegaly Y / N / NA Fever/infect		er/infection	on Y/N/NA		Antimicrobials		Y / N – if yes please specify			
Coagulopathy Y / N / I	NA Hae	morrhage	Υ/	N / NA						
Requesting doctor				Date						
SNBTS CD doctor taking request				Signa	ture					
Sample Requires To Be Transpo	rted By Urg	jent Courier Fo	r Same	Day Tes	ting?					Y/N
		Part 2: P	latele	et requ	uiren	ner	nts			
Name of hospital Blood Ba that platelets should be delivered to								plat	ate telets uired	

Please ensure the requesting team is aware of the need to both monitor post-transfusion platelet increments at 1 hour or 24 hours and the need to forward this information to the SNBTS using NATF1004. Requesting teams also need to communicate all requests to their own Blood Bank.

CMV

Neg

Rh(D)

Neg

Y/N

Y/N

Date

HPA

Selected

If Rh(D) negative components specified, would clinician accept Rh(D) positive?

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