

Person Completing Requisition		
Client	Client#	
Department	Phone	
Address		
City	ST	ZIP
Physician		



**BLOODCENTER**  
of WISCONSIN™

**PLATELET & NEUTROPHIL  
IMMUNOLOGY LAB**  
Phone 800-245-3117 x 6255  
Fax (414) 937-6245

**Patient/Sample Name**

MR #	Last	Accession #	First	MI
DOB	mm/dd/yyyy	Gender	SS #	-
Specimen Type	Ethnicity		Draw Date	mm/dd/yyyy
Anticoagulant	Draw Time			

**Indicate Special Reporting/Billing Requests**

**BloodCenter of Wisconsin does not bill patients or their insurance.**

PO# \_\_\_\_\_

Is testing for outpatient Medicare enrollee or Wisconsin Medicaid recipient? Yes  No  If yes, please complete information on reverse.

Diagnosis \_\_\_\_\_ Number of Pregnancies \_\_\_\_\_  
 Platelet Count \_\_\_\_\_ Number of Transfusions \_\_\_\_\_ Date of Most Recent Platelet Transfusion \_\_\_\_\_

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

<p>Drug Dependent Antibody  <input type="checkbox"/> Platelet (9000)  <input type="checkbox"/> Neutrophil (9500)        List drugs to be tested: (attach list if needed)        _____        _____</p> <p><input type="checkbox"/> Abciximab (Reopro™) Dependent Platelet Antibody (5900)</p> <p>Heparin-Dependent Platelet Antibody (<b>PF4 ELISA</b>)  <input type="checkbox"/> IgG (5510) (<input type="checkbox"/> Routine <input type="checkbox"/> STAT)  <input type="checkbox"/> IgA and IgM (5514)</p> <p><b>(STAT testing is available for IgG PF4 to local customers only. Please call 414-937-6255 to arrange STAT testing.)</b></p> <p>Heparin-Dependent Antibody (<b>Serotonin Release Assay</b>)  <input type="checkbox"/> Unfractionated Heparin (5508)  <input type="checkbox"/> Enoxaparin (LMWH) (5108)  <input type="checkbox"/> SRA Panel (Unfractionated and Enoxaparin) (5008)</p> <p><input type="checkbox"/> Platelet Glycoprotein Expression (PGE) (5545)        (To rule out Glanzmann Thrombasthenia or Bernard Soulier Syndrome)</p> <p><input type="checkbox"/> Platelet Antibody Screen (5543)</p> <p><input type="checkbox"/> Platelet Autoantibodies (5544)  <b>(Sample must be received within 4 days of draw. See Whole Blood Age Table on back.)</b></p> <p>Paroxysmal Nocturnal Hemoglobinuria (PNH)  <input type="checkbox"/> PNH - Leukocytes (5549)  <input type="checkbox"/> PNH - Erythrocytes &amp; Leukocytes (5550)</p> <p><input type="checkbox"/> Glycoprotein IV (CD36) Typing (5444)</p> <p>Neutrophil Antibody:  <input type="checkbox"/> Neutrophil Antibody Screen (5102)  <input type="checkbox"/> Neutrophil Antibody Screen and HLA Antibody Screen (5112)  <input type="checkbox"/> Neutrophil Antibody Identification and HLA Antibody Screen (5113)</p> <p><input type="checkbox"/> TRALI (Transfusion Related Acute Lung Injury)        (Includes Neutrophil Antibody Screen and HLA Antibody Screen)</p> <p>Neonatal Alloimmune  <input type="checkbox"/> <b>Thrombocytopenia</b> (5603/5703) (½ 5303)  <input type="checkbox"/> <b>Neutropenia</b> (5125/5126)        Father's Name _____        Date of Birth _____</p>	<p><input type="checkbox"/> Post-Transfusion Purpura (PTP) Panel (5631)</p> <p><input type="checkbox"/> Multitransfused Platelet Refractory (MPR) Panel (5632)</p> <p><input type="checkbox"/> Platelet Antibody Identification Panel (5608)        (HPA-1a/b, HPA-2a/b, HPA-3a/b, HPA-4a, HPA-5a/b, GPIIb/IIIa, GPIa/IIa, GPIb/IX, GPIV)</p> <p>Congenital Thrombocytopenia  <input type="checkbox"/> MPL Sequence Analysis (5760)  <input type="checkbox"/> WAS Sequence Analysis (5761)  <input type="checkbox"/> RUNX1 Sequence Analysis - Inherited (5763)  <input type="checkbox"/> MYH9 Sequence Analysis - Inherited (5765)</p> <p>Congenital Neutropenia  <input type="checkbox"/> ELA2 Sequence Analysis (5107)  <input type="checkbox"/> HAX1 Sequence Analysis (5762)  <input type="checkbox"/> WAS Sequence Analysis (5761)</p> <p><input type="checkbox"/> Neutrophil Antigen Genotyping Panel (5201)        (HNA-1a, HNA-1b, HNA-1c, HNA-3a/b, HNA-4a/b, HNA-5a/b)</p> <p>Neutrophil Antigen Genotyping – Individual  <input type="checkbox"/> HNA-1a, HNA-1b, HNA-1c (5250)  <input type="checkbox"/> HNA-3a/b (5203)  <input type="checkbox"/> HNA-4a/b (5204)  <input type="checkbox"/> HNA-5a/b (5205)</p> <p><input type="checkbox"/> Platelet Antigen Genotyping Panel (5600)        (HPA-1, HPA-2, HPA-3, HPA-4, HPA-5, HPA-6, HPA-9, HPA-15)</p> <p>Platelet Antigen Genotyping – Individual  <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)</p> <p><b>PLATELET ALLOANTIGEN NOMENCLATURE</b>        HPA-1a = Pl<sup>A1</sup> HPA-3a = Bak<sup>a</sup> HPA-5a = Br<sup>b</sup> HPA-9a = Max<sup>b</sup>        HPA-1b = Pl<sup>A2</sup> HPA-3b = Bak<sup>b</sup> HPA-5b = Br<sup>a</sup> HPA-9b = Max<sup>a</sup>        HPA-2a = Ko<sup>b</sup> HPA-4a = Pen<sup>a</sup> HPA-6a = Ca<sup>b</sup> HPA-15a = Gov<sup>a</sup>        HPA-2b = Ko<sup>a</sup> HPA-4b = Pen<sup>b</sup> HPA-6b = Ca<sup>a</sup> HPA-15b = Gov<sup>a</sup></p> <p>Comments _____        _____</p>
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BCW Use Only			
_____ EDTA	_____ Serum	Opened By	_____
_____ ACDA	_____ Amnio	Evaluated By	_____
_____ Clot	_____ Cyto-Chex	Reviewed By	_____
_____ Other	_____	Labeled By	_____

## SAMPLE REQUIREMENTS AND SHIPPING INSTRUCTIONS

Label samples clearly with full name of individual, date and time drawn.

Test	Sample Requirement						
Drug Dependent Platelet Antibody Abciximab Dependent Antibody Heparin Dependent Platelet Antibody (PF4 ELISA) (IgG, IgA and IgM) Heparin Dependent Antibody Serotonin Release Assay Platelet Antibody Screen Drug Dependent Neutrophil Antibody Neutrophil Antibody Screen Neutrophil Antibody Screen and HLA Antibody Screen Neutrophil Antibody Identification and HLA Antibody Screen	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.) <b>Send sample refrigerated.</b>						
Platelet Glycoprotein Expression (PGE)	<b>Contact lab before drawing.</b> 5 ml ACD-B whole blood from patient and a control (control must be from a volunteer donor unrelated to patient). ACD-A is acceptable if ACD-B is not available. <b>Send Next Day delivery Tuesday – Thursday. Send sample 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 Or PNH – Erythrocytes & Leukocytes	5 ml EDTA whole blood. Send sample refrigerated. <b>Sample must be less than 2 days old when received. Send FedEx Priority Overnight Monday – Thursday.</b>						
Glycoprotein IV (CD36 Typing)	10 ml ACD-A or EDTA whole blood. Send sample at room temperature						
TRALI (Transfusion Related Acute Lung Injury) (Includes Neutrophil Antibody Screen and HLA Antibody Screen)	5 ml serum and 5 ml EDTA whole blood from both patient and donor. <b>Send sample refrigerated.</b>						
Neutrophil Antigen Genotyping - Individual or Panel Platelet Antigen Genotyping - Individual or Panel ELA2 Sequence Analysis HAX1 Sequence Analysis MPL Sequence Analysis WAS Sequence Analysis RUNX1 Sequence Analysis – Inherited MYH9 Sequence Analysis – Inherited	3-5 ml EDTA whole blood 7-15 ml amniotic fluid 5 x 10 <sup>6</sup> cultured amniotic cells 1 ml Cord Blood <b>Send sample at room temperature or refrigerated.</b>  For your convenience, an informed consent form is available in our catalog or on our web site.						
Platelet Antibody Identification Panel	5 ml serum. <b>Send sample refrigerated.</b>						
Neonatal Alloimmune Thrombocytopenia (NAT or NATP) (Includes Platelet Antigen Genotyping Panel of mother and father and Platelet Antibody Identification Panel of mother including crossmatches)	30 ml ACD-A whole blood from mother and father 10 ml serum from mother <b>Each sample must be clearly labeled with the full name of individual, date and time drawn. See Whole Blood Age Table for draw date and received date requirements. Send sample refrigerated.</b>						
Post-Transfusion Purpura (PTP) (Includes Platelet Antibody Identification Panel and Platelet Antibody Genotyping Panel)	5-10 ml EDTA whole blood 10 ml serum <b>Send sample refrigerated.</b>						
Multitransfused Platelet Refractory (MPR) (Includes Platelet Antibody Identification Panel and Platelet Antibody Genotyping Panel)	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

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

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.

**Shipping Address: Client Services / PNIL**

**BloodCenter of Wisconsin  
638 North 18<sup>th</sup> Street  
Milwaukee, WI 53233-2121  
Phone: 800-245-3117 ext 6396**

### MEDICARE (OUTPATIENT) AND Wisconsin MEDICAID BILLING INFORMATION

BloodCenter of Wisconsin will bill the institution directly unless testing is performed on an OUTPATIENT Medicare enrollee or a Medicaid recipient from WI.

Medicare #	_____
Railroad Retiree #	_____
Medicaid #	_____ (Wisconsin only)
Patient's Address	_____
City	_____ State _____ Zip _____
Diagnosis	_____ ICD9 Dx Code _____
Referring Physician's Full Name	_____
Referring Physician's Provider # (NPI#)	_____ Physician's Phone Number _____