



**Blood Centers of the Pacific**  
 Irwin Center, SF  
 270 MASONIC AVE., SAN FRANCISCO, CA 94118  
 (415) 749-6681 (888) 673-3522 TOLL FREE

**PLATELET STUDIES REQUEST/BILLING**

CUSTOMER (HOSP/LAB/DR) \_\_\_\_\_ DATE \_\_\_\_\_  
 BILLING ADDRESS \_\_\_\_\_ P.O. # \_\_\_\_\_  
 \_\_\_\_\_ INVOICE # \_\_\_\_\_  
 ATTENDING PHYSICIAN \_\_\_\_\_ ACCOUNT # \_\_\_\_\_  
 PHONE # \_\_\_\_\_

PATIENT NAME \_\_\_\_\_  
 PATIENT OR SAMPLE ID # \_\_\_\_\_

**TEST REQUESTED**

- CROSSMATCH FOR COMPATIBLE UNITS  
 HOW MANY? \_\_\_\_\_ WHEN? \_\_\_\_\_
- HPA-1a ANTIGEN TYPING
- NEONATAL STUDY-INITIAL
- CHLOROQUINE NEONATAL STUDY
- PLATELET DONOR SCREEN X \_\_\_\_\_ DONORS
- PLATELET FAMILY SCREEN X \_\_\_\_\_ MEMBERS

**PATIENT INFORMATION:**

ABO \_\_\_\_\_ RACE \_\_\_\_\_ DOB \_\_\_\_\_

CURRENT COUNT \_\_\_\_\_ DATE TESTED \_\_\_\_\_

CLINICAL DIAGNOSIS \_\_\_\_\_

MEDICATIONS \_\_\_\_\_

TRANSFUSIONS (#, DATES & COMPONENTS):  
 \_\_\_\_\_

PREGNANCY HISTORY: YES  NO  # \_\_\_\_\_

THROMBOCYTOPENIC NEONATES? \_\_\_\_\_

**FOR BCP REFERENCE LAB USE ONLY**

| CPT CODE                       | TESTS PERFORMED       | DP CODE    | TOTAL           |
|--------------------------------|-----------------------|------------|-----------------|
| 86999 <input type="checkbox"/> | PLT CROSSMATCH        | 10663      | \$ _____        |
| 86999 <input type="checkbox"/> | HPA-1a ANTIGEN TYPING | 10667      | \$ _____        |
| 86999 <input type="checkbox"/> | NEONATAL STUDY        | 11435      | \$ _____        |
| 86970 <input type="checkbox"/> | CHLOROQUINE STUDY     | 11430      | \$ _____        |
| 86022 <input type="checkbox"/> | PLATELET ANTIBODY     | 10662      | \$ _____        |
| 86999 <input type="checkbox"/> | PLT DONOR SCREEN      | 10250      | \$ _____        |
| 86999 <input type="checkbox"/> | PLT FAMILY SCREEN     | 10655      | \$ _____        |
| 86999 <input type="checkbox"/> | CROSSMATCH-SELECTED   | 10670      | \$ _____        |
| \$ _____                       | X _____ UNITS         |            | \$ _____        |
| <input type="checkbox"/>       | OTHER                 |            | \$ _____        |
| <b>TOTAL CHARGE</b>            |                       |            | <b>\$ _____</b> |
| BCP Technologist _____         |                       | Date _____ |                 |

**REASON FOR SUBMITTING SAMPLE:**

- REFRACTORY PLT TRANSFUSION RECIPIENT
- NEONATAL THROMBOCYTOPENIA
- POST-TRANSFUSION PURPURA (PTP)
- OTHER (PLEASE SPECIFY) \_\_\_\_\_

**SPECIMEN REQUIREMENTS:**

PLATELET CROSSMATCH: 14mL EDTA WHOLE BLOOD  
 HPA-1a ANTIGEN TYPING: 21mL EDTA WHOLE BLOOD  
 NEONATAL STUDY:  
     Mother 21mL EDTA WHOLE BLOOD  
     Father 21mL EDTA WHOLE BLOOD

SUBMITTED BY \_\_\_\_\_ DATE \_\_\_\_\_

**CALL REFERENCE LABORATORY TO SCHEDULE TESTING. MAINTAIN AND TRANSPORT SAMPLES AT ROOM TEMPERATURE. SEND SAMPLES TO BLOOD CENTERS OF THE PACIFIC - ATTN: REFERENCE LABORATORY**