Complete and print.

Reset Form

MAYO CLINIC LABORATORIES

Platelet Antibody Screen, Serum Patient Information

Patient Information

Patient Name *(Last, First, Middle)*	Birth Date*(mm-dd-yyyy)*	Sex ☐ Male ☐ Female
Referring Provider Name *(Last, First)*	Phone	Fax
Referring Provider Email	Patient Medical Record Number (MRN)	

**Fax number given must be from a fax machine that complies with applicable HIPAA regulations.*

Reason for Testing/Diagnosis

☐ Refractory to platelet transfusion (PTR)
☐ Post-transfusion purpura (PTP)
☐ Neonatal alloimmune thrombocytopenia (NAIT)
☐ Alloimmune thrombocytopenia

Note: If idiopathic thrombocytopenia purpura (ITP) or secondary ITP, order cell bound platelet antibody (CBPAN) assay instead.

IVIg given in the last month ☐ Yes ☐ No
Platelet transfusion in the last 72 hours ☐ Yes ☐ No
Platelet count _____ x 10^9/L

Print