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 Assigned at Birth ☐ Male ☐ Female ☐ Unknown ☐ Choose not to disclose	Legal/Administrative Sex ☐ Male ☐ Female ☐ Nonbinary	

Referring Provider Information

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, consider cell bound platelet antibody testing. Call 800-533-1710 for testing options.

IVIg given in the last month	☐ Yes	☐ No
Platelet transfusion in the last 72 hours	☐ Yes	☐ No
Platelet count	$\times 10^9$/L	

Print