REQUEST FOR PLATELET CROSSMATCH

Name of Hospital/Laboratory: _____

Name of Patient: _____ Blood Type: _____

Date Specimen Drawn: _____ Number of Pheresis Needed: _____

Shipping Instructions: _____

_____

_____

Please notify laboratory before sending specimens. (865) 521-2640.

INSTRUCTIONS: *We require one freshly drawn (up to 48 hours) patient sample (plasma or serum) with no gel separator. We request sample delivery to Medic by 1:00 PM for same day testing. The procedure is available Monday-Friday from 8:00 AM to 4:00 PM.*

All crossmatched platelet products will be irradiated.

CROSSMATCHED PLATELETS ISSUED

UNIT #	COMPATIBILTY TESTING		COMMENT
	C	IC	

Crossmatch Date: _____ **Tech:** _____

KEY: *C = COMPATIBLE* *IC = LEAST INCOMPATIBLE*

MEDIC REGIONAL BLOOD CENTER
1601 AILOR AVENUE
KNOXVILLE, TN 37921

MEDIC 4.837A
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