

**PLATELET IMMUNOLOGY LABORATORY**

Laboratory Staffed for Questions 8:00am – 4:30pm, Monday-Friday

921 Terry Ave, Seattle, WA Phone: (206) 689-6543 Fax (206) 689-8378 Website: <https://www.bloodworksnw.org>

**Routine Tests**

**Drawing Instructions**

Samples accepted Sunday-Thursday, 24 Hrs/Day, Friday before 10:00am

3630-00	<input type="checkbox"/>	Platelet Alloantibody Workup-Basic (Refractory to Platelet Transfusions)	10cc ACD (yellow top) and 10cc clot (red top)										
3635-00	<input type="checkbox"/>	Platelet Alloantibody Workup - Advanced											
3084-00	<input type="checkbox"/>	HLA Class I (A,B,C) Typing											
			<b>Patient must be transfusion independent for 5 days.</b> 5cc citrate (blue top) and EDTA tubes (lavender top) *Refer to chart below <b>Samples must be less than 48 hours old.</b>										
3640-00	<input type="checkbox"/>	Platelet Autoantibody Test (ITP Workup)	<table border="1"> <thead> <tr> <th>Platelet Count of Patient</th> <th>Volume of EDTA-anticoagulated Blood</th> </tr> </thead> <tbody> <tr> <td>Greater or equal to 50,000</td> <td>20cc EDTA</td> </tr> <tr> <td>20,000 to 49,999</td> <td>30cc EDTA</td> </tr> <tr> <td>10,000 to 20,000</td> <td>40cc EDTA</td> </tr> <tr> <td>Less than 10,000</td> <td>DO NOT DRAW *Contact Lab</td> </tr> </tbody> </table>	Platelet Count of Patient	Volume of EDTA-anticoagulated Blood	Greater or equal to 50,000	20cc EDTA	20,000 to 49,999	30cc EDTA	10,000 to 20,000	40cc EDTA	Less than 10,000	DO NOT DRAW *Contact Lab
Platelet Count of Patient	Volume of EDTA-anticoagulated Blood												
Greater or equal to 50,000	20cc EDTA												
20,000 to 49,999	30cc EDTA												
10,000 to 20,000	40cc EDTA												
Less than 10,000	DO NOT DRAW *Contact Lab												
3260-01	<input type="checkbox"/>	ADAMTS 13 Activity	5cc citrate (blue top)										
3260-02	<input type="checkbox"/>	ADAMTS 13 Inhibitor (test performed if activity level < 30%)	<b>Spin within 4 hours</b> of being drawn, freeze the plasma at -20°C and then ship frozen specimen on dry ice.										
3260-03	<input type="checkbox"/>	ADAMTS 13 Antibody (test performed if activity level < 30%)	*For Inhibitor and Antibody tests, an evaluation is performed which includes an immunologic assay (ELISA) and a functional assay.										
3655-10	<input type="checkbox"/>	Heparin/PF4 IgG ELISA	5cc citrate (blue top) unspun or frozen citrate plasma										
3655-20	<input type="checkbox"/>	Heparin/PF4 IgG ELISA Confirmation	<b>If sending over the weekend. Spin and freeze plasma at -20°C and send frozen on dry ice</b>										
3655-00	<input type="checkbox"/>	Heparin Antibody Test-Platelet Factor 4 ELISA (IgG,IgA,and IgM)											
3650-00	<input type="checkbox"/>	Platelet Drug Antibody Test Drug _____	Contact lab for sample and drug requirements										
3660-00	<input type="checkbox"/>	Post-Transfusion Purpura Workup	10 cc EDTA (lavender top), 10cc citrate (blue top), 10cc clot (red top)										
3670-00	<input type="checkbox"/>	Neonatal Alloimmune Thrombocytopenia Evaluation <u>Father Information</u> Name: _____ Hospital No: _____ Date of Birth: _____ Collection Date: _____	<b>Samples must be less than 48 hours old</b> <b>Mother:</b> 20cc EDTA(lavender top), 10cc citrate(blue top),10cc clot(redtop) <b>Father:</b> 20cc EDTA(lavender top)										
3680-00	<input type="checkbox"/>	Platelet Typing for Single Platelet Antigen Other _____	10cc EDTA (lavender top) or ACD (yellow top)										

**Specimen Information: Fill in ALL of Box Below**

COLLECTION DATE: ____/____/____ Time ____ <input type="checkbox"/> am <input type="checkbox"/> pm		Drawn by _____
Specimen/Accession No: _____		ICD10Code _____
Physician or Authorized Person Ordering Test: FIRST _____ LAST _____		
<b>Patient Identification</b> (Name on Sample)		<b>Send Report To:</b>
LAST _____		Institution _____
FIRST _____	MI _____	Fax Number _____
Hospital Identification Number _____		Street _____ City, St, Zip _____
Hospital /Institution _____		Contact Person: _____ Phone No _____
Date of Birth _____	Sex (M/F) _____	Bill To: (BWNW bills to institutions not to 3 <sup>rd</sup> party payers)
		Institution _____

Comments: \_\_\_\_\_ Street \_\_\_\_\_ City, St, Zip \_\_\_\_\_

Additional Specimen and Test Requirements – for current test descriptions and CPT codes visit <https://www.bloodworknw.org>

All samples must be properly labeled and the information must agree with the identification on the request for testing. A specimen identified by a name must also provide a numeric identifier which may include hospital number, SSN, or other coded identifier. A draw date must be on the sample and/or request for testing form to be acceptable. All samples must be sent to Bloodworks Northwest in a sealed, leak proof container marked with a biohazard sticker to comply with OSHA safety standards. **Ship at ambient temperatures.**