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) | Medical Record Number |
|---|---|---|
| | | |

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

## Referring Provider Information

| Requesting Provider Name (Last, First) | | |
|---|---|---|
| Phone | Fax* | Email |
| | | |

**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, call 800-533-1710 for testing options.

IVIg given in the last month: ☐ Yes ☐ No

Print