

## HLA/HPA SELECTED PLATELET PROVISION REQUEST FORM

## TO BE COMPLETED BY PATIENT'S SPECIALIST CLINICAL TEAM

Please email completed forms to WBS SelectedPlatelets@wales.nhs.uk PROVIDE A COPY TO THE HOSPITAL TRANSFUSION LABORATORY TO ENSURE RECEIPT OF PLATELETS

Please ensure you have discussed this request with a member of staff in WTAIL by calling 01443 622186, and have sent appropriate samples for HLA/HPA antibody investigation.

10ml CLOTTED and 40ml EDTA are required. Contact the WTAIL paediatric patients or those difficult to bleed.

\*This information is mandatory. Failure to adequately complete this information may result in a delay.

*SURNAME				*FORENAME					
*NHS N°									
*DOB —/—/—				*Sex Male Female					
Hospital No If NHS Nº not available Hospital Nº MUST be provided									
Referring Hospital				Consultant					
*ABO / Rh Group				Ward					
*Diagnosis/(	*Diagnosis/Clinical Details								
<u></u>									
CMV Status:	Positive			Negative					
Weight (kg)				Height (cm)					
Clinician Completing Form				*Talanhana No					
*Name	*Name *Signature			*Telephone N° *Bleep N°					
Additional patient Chemo			_						
		Cher	no 🗌	Post Chemo		Post B	MT	ATG 🗌	
information	•		mo 🗌	Post Chemo			_		
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Please inform the WTAIL if platelets are no longer required to prevent unnecessary provision of a limited, time-intensive resource.