Australian Red Cross
BLOOD SERVICE

REQUEST FOR SINGLE DONOR PLATELETS

INFORMATION SHEET

APHERESIS UNIT TELEPHONE & FAX NUMBER
(03) 9694 0337
(Office hours 0800 - 1630 Monday - Friday)

- A Positive and O Positive Apheresis Platelets may be available from Inventory & Distribution. Contact 9694-0200 to request.

- **At least 24 hours** notification is required in order to arrange a voluntary ARCBS- VIC donor to attend an Apheresis / Cell Separator Unit for a Cytapheresis collection.

- Complete the request form overleaf and fax as soon as possible. **Donors will only be selected once this form is received at ARCBS.**

- Subsequent collections for the same patient, may be ordered by a Cell Separator Unit Staff Member or a Blood Service Scientist under the direction of the attending Medical Officer. These requests are made by contacting the Apheresis Unit on (03) 9694 0337 during office hours (as above).

- A **change in recipient requirements** requires another **Request For Cytapheresis Collection Form** to be completed and faxed by the requesting doctor. If a donor cannot be arranged, the requesting doctor will be notified.

- For urgent **after hours/public holiday requests** of non-directed platelets, please call the Inventory & Distribution Unit, on (03) 9694 0200 and ask to speak to the Haematologist on call .

For advice regarding platelet support contact the Transfusion Medicine Specialist or designate on (03) 9694 0200.

- Further details regarding Cytapheresis collections are in your Information Package located at your centre.

WHEN REQUESTING CYTAPHERESIS COLLECTION, PLEASE RETURN PAGE 1 VIA FAX

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REQUEST FOR CYTAPHERESIS COLLECTION

URGENT

Attention -APHERESIS UNIT **Date of request :** ____________________

APHERESIS UNIT TELEPHONE & FAX NUMBER: (03) 9694 0337

PATIENT DETAILS

Name: **D.O.B:** **UR Number:** **(attach hospital label if available)** **Hospital:** **Ward:** **Current Platelet Count:** **Date of last result:**	**Diagnosis:**____________________ **ABO Group:**____________________ **Where was HLA typing performed: ARCBS**☐ **Other**☐ (if *other* please fax HLA typing report) **Date of typing:** **HLA antibodies tested Yes** ☐ **No** ☐ **Date**___/___/___ **If No, serum to be sent to ARCBS-Vic** **% Panel Reactive: Size of panel** ✓ **if not known** ☐ **Specific HLA antibodies (if known)** ✓ **if not known** ☐

Current platelet transfusion therapy: ____________________
Reason for Single Donor Platelets : ____________________

SINGLE DONOR PRODUCT REQUESTS (please ✓)

☐ **ABO Matched Platelets** ☐ **HLA Matched Platelets** ☐ **Granulocytes**
☐ **CMV Negative Status Required:** ☐ **Disregarding CMV Staus**

Nucleic Acid Testing (NAT) for Hepatitis C and HIV 1 is performed on all collections. The decision to transfuse prior to availability of NAT results is the Clinician's responsibility, see SF001652 – Screening Test Request and Results. Due to NAT processing requirements, sometimes NAT results will not be available as soon as ABO and Virus Serology results.

NAT results required prior to transfusion? *(please tick)* YES ☐ **NO** ☐

INITIAL COLLECTION DETAILS
Site: **Date & Time:**

REQUESTING MEDICAL PRACTITIONER'S DETAILS
Requesting Dr's Name: (please print) **Consultant's Name:**
Signature: **Contact Number**
Blood Bank Fax No for results: **Blood Bank Results Phone No For testing results only**

Office Use Only (please ✓)

Approved By: **Yes** ☐ **No** ☐
Reason why not approved: