Belfast Health and Social Care Trust
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Regional Fertility Centre

Semen Analysis Request Form

*********Referral form will be returned if ALL information below is not provided.************

PATIENT DETAILS ***Apply label if applicable***
Forename:_____ Surname:_____ Gender: Male / Female (please circle) Date of Birth: _____/_____/_____ ****Health & Care No**._____ Partner Reference No._____ (*if Applicable*)
Patient Address:_____ _____ Contact No: _____

High Risk (*known* or *suspected* carrier of *Category 3 pathogens*, e.g. HIV, Hepatitis B or C)

YES / NO

(MUST circle/delete) ***

If Yes please specify:

Relevant clinical information:

Interpreter Required: ☐

Language:_____

Referrers details *(not required by RFC Dr`s)*	Referrer's Name: _____ Address: _____ _____ Tel No: _____
Address for result if different from above	
Date of referral ___/____/_____	Signed: _____ Print Name:_____

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The completed form should be returned to:
Regional Fertility Centre, RJMS, Grosvenor Road, Belfast BT12 6BA
Internal Trusts referrals may be emailed to: rvh.rfc@belfasttrust.hscni.net

The RAS user manual can be found on our website - http://www.rfc.hscni.net/

Sample received *(to be completed by RFC andrology staff)*
Date: ____/_____/___ Name: _____ Signature: _____
Time produced: _____ Time received: _____