



## 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 / Other (please specify)  
\_\_\_\_\_

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](mailto:rvh.rfc@belfasttrust.hscni.net)

**The RAS user manual can be found on our website –**

**<https://belfasttrust.hscni.net/service/regional-andrology-service/>**

Sample received (to be completed by RFC andrology staff)

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Time produced: \_\_\_\_\_ Time received: \_\_\_\_\_