



Sperm Storage Request Form

MALE DETAILS <i>Apply label if applicable</i>	Clinical reason for referral:
Forename: _____	_____
Surname: _____	_____
Date of Birth: ____/____/____	RED FLAG REFERRAL? - YES / NO
Health & Care No. _____	(Please delete appropriate YES / NO)
Patient Address: _____	Date of Treatment/Surgery: ____/____/____
_____	Will patient be accompanied by a nurse?
Contact No: _____	If 'Yes' please tick box ☐
Patients GP Details: _____	<i>All inpatients should be accompanied and a list of medications provided</i>
_____	Interpreter Required ☐
	Language _____

N.B. Screening Requirements: All patients are required to have been screened for (1) Hep B surface antigen (HBsAg), (2) Hep B core antigen antibody (anti-HBc), (3) Hep C and (4) HIV 1&2, prior to attending any appointment at the RFC. Results **MUST** be available at time of referral as appointments cannot be arranged without screening results

Referrers details <i>(not required by RFC Dr's)</i>	Referrer's Name: _____
	Address: _____
	Contact No. _____
Address for result if different from above	
Date of referral ____/____/____	Signed: _____ Print Name: _____

Referral form will be returned if all of the information requested above is not provided.

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

For Completion in Laboratory ONLY
Date Sample Received: ____/____/____ Time Sample Received: _____
Further Information: _____