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 / 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

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: