Sperm Storage Request Form

MALE DETAILS
Apply label if applicable

Forename:_____

Surname:_____

Date of Birth: _____/_____/_____

Health & Care No._____

Patient Address:_____

_____

Contact No: _____ Patient / other
(Circle as appropriate)

Patients GP Details: _____

_____

Clinical reason for referral:

_____

_____

RED FLAG REFERRAL? - YES / NO

(Please delete appropriate YES / NO)

Date of Treatment/Surgery: ___/___/___

Will patient be accompanied by a nurse?

If 'Yes' please tick box ☐

All inpatients should be accompanied and a list of medications provided

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 total antibody (anti-HBc), (3)Hep C antibody & (4) HIV 1&2, prior to attending any appointment at the RFC.** If using EPIC select '**MALE FERTILITY PRESERVATION SCREEN'** panel. **Results MUST be available at time of referral** as appointments cannot be arranged without screening results

Referrers details *(not required by RFC Dr`s)*	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: