Belfast Health and Social Care Trust
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Regional Fertility Centre

Sperm Storage Request Form

MALE DETAILS *Apply label if applicable*	**Clinical reason for referral:**
Forename:______________________________ Surname:__________________________ Date of Birth: ________/________/_______ Health & Care No._________________________	______________________________________ ______________________________________ **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 ☐
Patient Address:_________________________________ ____ Contact No: ___________________________________ Patients GP Details: _____________________________ ____	***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 antigen antibody (anti-HBc), (3)Hep C, (4) HIV 1&2 and (5)COVID-19 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 *(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: ____