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 ☐ ***All inpatients should be accompanied and a list of medications provided*** Interpreter Required ☐ Language_____
Patient Address:_____ _____ Contact No: _____ Patients GP Details: _____ _____	

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: _____