



## Sperm Storage Request Form

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

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