Access. no._____

DFW CENTER FOR FERTILITY & IVF

980 Raintree Circle, Allen, TX 75013
Phone (214) 383-2600 Fax (214) 383-2601

ANDROLOGY LABORATORY REQUISITION

Name:_____

Partner Name:_____

Date:_____

Requesting Physician Signature:_____

Requesting Physician:_____

Physician Phone: _____

Physician Fax:_____

Patient's DOB:_____Age:____ Phone #:_____

PROCEDURE REQUESTED

- ☐ Semen Analysis
- ☐ Semen Analysis / Post Vasectomy
- ☐ Anti-sperm Antibodies
- ☐ Sperm Cryopreservation
- ☐ IUI Sperm Preparation with Husband Sperm
- ☐ IUI Sperm Preparation with Donor Sperm
- ☐ IVF Sperm Processing

Special Comments: _____

Reason/Diagnosis Code: _____

Identity Verified by:_____ Photo ID on file:_____ Receiving Technologist:_____

Specimen Information

Collection Date:_____ Days of abstinence:_____

Collection Time:_____ Time Received in Lab:_____

Collection Information

Collection site:	☐ On Site	☐ Off-site	
Method of Collection:	☐ Masturbation	☐ Seminal collection device	☐ Other:_____
Collection:	☐ Complete sample	☐ Incomplete sample? – Reason:_____	
Container:	☐ Lab provided	☐ Pharm/Phys Provided	☐ Other:_____
Post Vasectomy:	☐ Yes	☐ No	

- **Patient**: *I authorize DFW Center for Fertility and IVF, its employees and agents to process the semen specimen I have produced here or off-site. I verify that the specimen is properly labeled and is mine.*

  Patient Signature:_____ **DOB**:_____

- **Partner**: *I authorize DFW Center for Fertility and IVF, its employees and agents to process the semen specimen my partner produced off-site. I verify that the specimen is properly labeled and was produced by my partner.*

  Partner Signature:_____ **DOB**:_____