DFW CENTER FOR FERTILITY & IVF
980 Raintree Circle, Allen, TX 75013
Phone (214) 383-2600 Fax (214) 383-2601

Semen Analysis Request Form

Patient name: _____ Patient DOB: _____

Patient phone number: (____)_____

Female partner name: _____

Referring physician: _____

Referring physician signature: _____

Date: _____ Phone number: (____)_____

Please check appropriate test requested

☐ Complete semen analysis CPT 89320

☐ Anti-sperm antibody testing CPT 89325

☐ Sperm DNA fragmentation testing

☐ Semen analysis post vasectomy CPT 89321

Date of collection: _____ Time of collection: _____

Days since last ejaculation: _____ Collection site: on site / off site

Collection method: Masturbation / Collection condom

Accepting technologist _____ Date/Time: _____

Patient: I authorize DFW Center for fertility & IVF and its employees to process the semen specimen I have produced and I verify that the specimen is mine and labelled appropriately
Signature: _____ SSN: XXX-XX-_____

Spouse: I authorize DFW Center for fertility & IVF and its employees to process the semen specimen my partner produced off site and I verify that the specimen was produced by my partner and labelled appropriately
Signature: _____ SSN: XXX-XX-_____