University Women's Healthcare-Fertility Center
401 E. Chestnut, Ste. 410 - Louisville, KY 40202
Tel. 502-271-5846; Fax 502-271-5984

PHYSICIAN'S REQUEST FOR SPERM BANKING

I ____, request that the Fertility Center of University OB/GYN Associates perform for:

Mr.____

[ ] Semen analysis and semen cryopreservation

[ ] Testicular tissue/aspirate processing and cryopreservation.

[ ] I also request that you perform a freeze-thaw test to determine the percentage of sperm that will survive freezing and thawing (optional).

[ ] Do not perform the freeze-thaw test.

I ask that you fax the results and if applicable, the freeze-thaw test results to the number below.

____
Signature of physician

____
Fax number

____
Telephone where physician can be reached