FERTILITY SOLUTIONS INC. LABORATORY REQUISITION

11811 Shaker Blvd., Suite 330
Cleveland, Ohio 44120
216-491-0030 x200 (Telephone)
216-491-0032 (Fax)
CLIA # 36D0698908

FOR PATIENT TO COMPLETE
TIME SEMEN COLLECTED __________ am/pm
TIME RECEIVED IN LAB __________ am/pm
TIME SINCE LAST EMISSION ________________hours/days
WAS ANY PART OF SAMPLE LOST OR SPILLED? YES NO
MEDICATIONS ____________________________________

DATE: ______________________

PATIENT NAME: ___________________________ SOCIAL SECURITY NUMBER: ______________________
ADDRESS: _________________________________ DATE OF BIRTH: __________________________________
CITY/STATE/ZIP: ___________________________ DAY TELEPHONE: _________________________________
EVENING TELEPHONE: ____________________________
PHYSICIAN: _______________________________ OFFICE TELEPHONE: ______________________________
ADDRESS TO: ______________________________ OFFICE FAX #: ___________________________________
SEND REPORT: ____________________________ ICD-9 CODE(S): __________________________________

ANDROLOGY DIAGNOSTICS

SPERM COUNT AND FUNCTION	
	Complete Semen Analysis (Includes Vol., Consistency, Count, Motility, Motion Analysis, Morphology)
	Sperm Count Only (Post Vasectomy Screen)
	Sperm Motion Analysis Only
	Sperm Viability Stain
	Sperm Morphology Only (WHO 3rd Edition and Strict Criteria)
	Semen Special Stain: _______________
	Urine Examination for Retrograde Semen Emission

ANTISPERM ANTIBODY TESTS	
Material for Assay	
	Sperm – Direct Immunobead
	Seminal Plasma
	Serum (No phlebotomy service available from Fertility Solutions Inc. Must be drawn outside)
	Cervical Mucus (Must be collect in weighed vial from Fertility Solutions - call for supplies)
Type of testing	
	Immunobead Screen, if positive antibody typing will be performed
	Immunobead Titer

SEMEN BIOCHEMISTRY	
	Fructose, qualitative

Comments or special instructions: ____

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Physician's Signature: ____