**Semen Analysis Request Form**

**(Infertility only – we do not carry out post vasectomy tests)**

**Patient Details**

|  |  |
| --- | --- |
| Patient Name: | Date of Birth: |
| Patient NHS Number: | Address: |
| Telephone Number: |  |
| E-mail address: |  |
| Partner Name: |  |

**Referring GP Details**

|  |  |
| --- | --- |
| GP Full Name: | GMC Number |
| GP Telephone Number: | GP Surgery Address |
| E-mail Address: |  |
| Signature of referring GP: |  |
| Date: |  |
| Any useful additional clinical information (including results of previous semen analysis) | |

|  |
| --- |
| *Clinic Use only* ID No. |

Please return this completed form by email or post:

* Email: [plh-tr.crgwplymouth@nhs.net](mailto:plh-tr.crgwplymouth@nhs.net) or [info@crgwplymouth.co.uk](mailto:info@crgwplymouth.co.uk)
* **Or Post:** CRGW Plymouth, 10 William Prance Road, Derriford, Plymouth, PL6 5WR

**The Clinic will contact the patient to provide further instruction, sample pots (if required) and arrange an appointment.**