WHUK ANDROLOGY

Semen Analysis Request Form

0845 686 1540

All Fields MUST be completed

Male Partner:

First Name:
Family Name:
Date of Birth:
Address:

NHS No:
Telephone No:
E-mail:

Female Partner:

First Name:
Family Name:
Date of Birth:
Address:

Clinical History:

Referred by:

Doctor:

Address:

I would like the result to be faxed to this number:

I undertake to explain the result to the patient

Signed:

Date:

Responsibility for Payment:
(Please circle)

PP: Patient Referring Doctor

NHS: PCT or GP Consortium
Address:

For Office Use

Women's Health UK Ltd. Incorporated in England and Wales No: 6343147
Registered Office: 60 London Rd, St Albans, AL1 1NG **(please do not bring your sample to this address, call the office to book an appointment on 0845 686 1540)**