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Document Title: Leighton Hospital Semen Analysis Referral Form		
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Leighton Hospital Semen Analysis Referral Form

Date of referral: _____

Patient details: Name: Date of birth: NHS no: Mobile number:	Patient Address: Please inform the patient that a pack will be sent to this address

Details of referring clinician:

Clinician's Name:

Clinician's/Practice Address:

NB. Results are returned via post to the clinician within 10 working days of the patient's test.

Appointment type required:

Fertility semen analysis ☐

Post-vasectomy semen analysis ☐ Date Procedure performed_____

Post-vasectomy reversal semen analysis ☐ Date Procedure performed_____

Additional information: e.g. Relevant clinical history, history of violence/aggression, viral risk, disability etc.

NB. If interpreter is required, please arrange one for your patient once they receive their appointment date.

Please return this form via email to semen.analysis@mhct.nhs.uk

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