THE LEEDS TEACHING HOSPITALS NHS TRUST

Lab use only

Case no

SEMENOLOGY REQUEST

PLEASE COMPLETE THIS FORM AND BRING WITH THE SAMPLE
(See patient guidelines)

Addressograph / capitals:

NHS No:

NAME

ADDRESS

DATE OF BIRTH

CONSULTANT/GP

SURGERY/CLINIC ADDRESS

Department of Histopathology
Histopathology Andrology Unit
Seacroft Hospital
Leeds,
LS14 6UH.

Tel no (office): 0113 2067110

Tel no (laboratory): 0113 2063127

If **PRIVATE** tick:

REQUEST TYPE (Please Tick The Appropriate Box):

☐ INFERTILITY

☐ POST VASECTOMY ☐☐/☐☐/☐☐ DATE OF VASECTOMY

☐ FIRST ☐ SECOND ☐ OTHER

☐ REVERSAL OF VASECTOMY

Lab use only

Date received:

Time received:

Received by (initials):

SAMPLE DETAILS:

Date of ejaculation …… Time of ejaculation……

Was this a complete sample? Yes ☐ No ☐ (please tick)

Days refraining from any sexual activity that results in ejaculation (length of abstinence) …….. (days)

ANY OTHER RELEVANT CLINICAL DETAILS

I (patient/patient representative) confirm that the information provided on this form is correct

Signature (patient/patient representative) ……

Full name (if patient representative) ……