Semen/ Testicular Tissue

TREATMENT HISTORY

All information is REQUIRED, where applicable

Name: ______________________________ **Account:** __________

Clinical Diagnosis: ____

Referring Physician (i.e. Oncologist, Urologist) who referred you for cryobanking:
Name:_____________________________ **Clinic Name:**______________
Address:____
Phone #:____

Reason for Semen/Testicular Tissue Cryobanking **(Please check the applicable selections.)**

Vasectomy:
____Pre-vasectomy
____Post-vasectomy

Cancer Treatment:
____Pre-Radiation Therapy
____Pre-Surgery
____Pre-Chemotherapy
____Between Treatments

Fertility Treatment:
____IVF Backup
____Donation
____Use by a Friend
____Use by a Surrogate
____Use by a Gestational Carrier
____Other, Please specify_________

High Risk Occupation:
____Military Service/Deployment
____Other (Hazardous chemicals, etc.), Please specify______________________________

Treatment History: **Please indicate applicable treatments or therapies and dates:**

	None	Past	Future
Vasectomy			
Chemotherapy			
Radiation Therapy			
Surgery			

Fertility History:
Number of pregnancies: ______ **Number of live births:** ______

Comments: ____

Your signature below acknowledges that the semen/testicular tissue specimens provided to RTL for the purpose of long term storage have been produced by and are the property of the undersigned. It is understood and agreed that future serology testing may be required for storage and/or release of these specimens.

Signature ____________________________________ **Date** __________

If the Patient above is a minor, a parent or guardian of the minor must sign below:

Signature of Parent or Guardian, if applicable:_____________________________

The Cryostorage & Compliance Experts
Florida 888.953.9669 • Minnesota 888.489.8944 • Nevada 888.831.2765 • Texas 888.350.3247