

**Requisition for Testing**  
 Reproductive Testing Laboratory  
 Center for Advanced Reproductive Care  
 UIHC, Department of Ob-Gyn Room 40015, Bldg. PFP  
 Iowa City, IA 52242 Phone: (319) 384-8352 Fax: (319) 384-8353

Patient Name: \_\_\_\_\_

Patient UIHC #: \_\_\_\_\_

Patient DOB: \_\_\_\_\_

**Appointment Scheduling:**

• **Prior to scheduling an appointment:**

- The referring physician **must** complete this requisition. The requisition may be faxed to 319-384-8353 or may be delivered by the patient when they check-in for their appointment.
- All patients seen by the laboratory must have a UIHC medical record number. If they have not been seen previously at UIHC, the patient should contact UIHC Registration at 1-866-309-0832 to complete registration.

• **Scheduling an appointment:**

- Call 319-384-8352 to schedule an appointment. Office hours are 8:00 am to 4:30 pm.
- Appointment times are available between 8:30 am and 3:00 pm for semen analysis. Cryopreservation appointments are available between 8:30 am and 2:00 pm.

**Patient Preparation:**

- We recommend that patients have 2 to 7 days of sexual abstinence prior to semen collection to optimize sperm concentration and quality.
- Patients should bring photo identification to their appointment.

**Directions to the RT-IVF Laboratory:**

- Please park in Ramp 4 and use the skywalk on Level 2 to reach the Pomerantz Family Pavilion. Follow the signs to Elevator L. The first elevator to the left will be Elevator L. Take Elevator L to the 4<sup>th</sup> floor. When you exit the elevator turn right. The Center for Advanced Reproductive Care waiting area will be directly in front of you, Room 40015. Check in with the secretary on arrival. If no one is present, pick up the phone to the left of the window and press the "Lab" button. This will notify the lab that you are here for your appointment.

**Procedure(s) Requested:** *Please check the box or boxes that correspond to the procedure requested.*

- |  |  |
|--|--|
| <input type="checkbox"/> <b>Initial semen analysis w/ morphology evaluation</b><br>(volume, count, motility, differential with morph)<br>CPT #14589322 [Diagnostic Testing-Male V26.21]  | <input type="checkbox"/> <b>Cryopreservation with semen analysis prior to oncology treatment CPT #14589320, CPT #14589259 [Prior to Oncology Treatment- V26.82]</b>    |
| <input type="checkbox"/> <b>Follow up semen analysis without morphology</b><br>(volume, count, motility, differential)<br>CPT#14589320 [Diagnostic Testing-Male V26.21]                  | <input type="checkbox"/> <b>Cryopreservation with semen analysis-non-oncology patient CPT #14589320, CPT #14589259 [Preservation of Fertility-non-oncology- 606.9]</b> |
| <input type="checkbox"/> <b>Post vasectomy reversal semen analysis</b><br>(volume, count, motility, differential) CPT #14589320<br>[Aftercare following sterilization reversal - V26.22] | <input type="checkbox"/> <b>Sperm evaluation, for retrograde ejaculation, urine CPT #14589331 [Diagnostic Testing - Male V26.21]</b>                                   |
| <input type="checkbox"/> <b>Post vasectomy semen analysis</b><br>(volume, count, motility, differential) CPT #14589320<br>[Post-vasectomy sperm count - V25.8]                           | <input type="checkbox"/> <b>Semen Fructose Assay for Azoospermia CPT #14582757 [Azoospermia 606.0]</b>   |
|  | <input type="checkbox"/> Other: _____  |

I request the laboratory to perform all testing on this specimen that are deemed medically necessary.

\_\_\_\_\_  
 Ordering physician's signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Physician's Name or CLP #  
 (please print)

\_\_\_\_\_  
 FAX #

Mailing Address – required for physicians outside of UIHC