

Requisition for Testing

Reproductive Testing Laboratory

UIHC, Department of Ob-Gyn **Room 40015 Pomerantz Family Pavilion**

Iowa City, IA 52242

Phone: (319) 384-8352

Fax: (319) 384-8353

Patient Name: _____

Patient UIHC #: _____

Patient DOB: _____

- **Appointment Scheduling:** Patients should contact the laboratory to schedule an appointment.
- **Patient Preparation:** We recommend that patients have 2 to 7 days of sexual abstinence prior to semen collection to optimize sperm concentration and quality.
- **Directions to the RT-IVF Laboratory:** For your convenience, please park in Ramp 4 and use the skywalk on Level 2 to reach the Pomerantz Family Pavilion. Follow the signs to the Pomerantz Family Pavilion and elevator L. Walk past the Skywalk Corner Café. The first elevator to the left will be Elevator L. Take elevator L to the 4th floor. When you exit the elevator turn right. The Center for Advanced Reproductive Care waiting area will be directly in front of you, in Room 40015. Enter through the door marked "Patient Entrance" and check in with the secretary. 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.

Information required for samples received by referring clinic:

Days of continence: _____

Time of sample collection: _____

Clinic Staff Receiving Sample: _____

Procedure(s) Requested

Please check the box or boxes that correspond to the procedure requested.

- | | |
|--|--|
| <input type="checkbox"/> Semen analysis CPT #14589320 | <input type="checkbox"/> Urine analysis for retrograde ejaculation CPT #14589240 |
| <input type="checkbox"/> Semen analysis w/morphology evaluation CPT #14589320 | <input type="checkbox"/> Sperm Identification from Testis Tissue CPT #14589264 |
| <input type="checkbox"/> Sperm cryopreservation CPT #14589259 | <input type="checkbox"/> Sperm Identification from Aspiration CPT #14589257 |
| <input type="checkbox"/> Semen Analysis; Presence and/or Motility of Sperm (Post Vasectomy Only) CPT #14589321 | <input type="checkbox"/> Cryopreservation, Reproductive Tissue, Testicular CPT #14589337 |
| <input type="checkbox"/> Semen Fructose Assay CPT #14582757 | |
| <input type="checkbox"/> Sperm Isolation; Complex Prep & Semen Analysis CPT #14589261 Indicate number of cycles: _____ | <input type="checkbox"/> Other: _____ |

Clinical Indication

- | | |
|--|---|
| <input type="checkbox"/> Infertility Diagnosis or Treatment | <input type="checkbox"/> Sperm banking prior to treatment |
| <input type="checkbox"/> Confirmation of Azoospermia following Vasectomy | <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