

**Requisition for Testing**  
 Reproductive Testing Laboratory  
 UIHC, Department of Ob-Gyn Room 573, Bldg. MRF  
 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:** Enter through the main entrance of the University of Iowa Hospital. Veer left past registration and take Elevator C to 5<sup>th</sup> Floor. Take a right off the elevator and then take the first left (across from the Helen K. Rossi Guest House). Proceed through the brown double doors. The laboratory is half way down the hallway on the right side of the hallway in Room 573, MRF.

**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<br><input type="checkbox"/> Semen analysis w/morphology evaluation CPT #14589322<br><input type="checkbox"/> Sperm cryopreservation CPT #14589259<br><input type="checkbox"/> Semen Analysis; Presence and/or Motility of Sperm (Post Vasectomy Only) CPT #14589321<br><input type="checkbox"/> Semen Fructose Assay CPT #14582757<br><input type="checkbox"/> Sperm Isolation; Complex Prep & Semen Analysis CPT #14589261 Indicate number of cycles: _____ | <input type="checkbox"/> Urine analysis for retrograde ejaculation CPT #14589240<br><input type="checkbox"/> Sperm Identification from Testis Tissue CPT #14589264<br><input type="checkbox"/> Sperm Identification from Aspiration CPT #14589257<br><input type="checkbox"/> Cryopreservation, Reproductive Tissue, Testicular CPT #14589335<br><input type="checkbox"/> Other: _____ |
|--|--|

**Clinical Indication**

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