Northwestern Medicine®

FERTILITY AND REPRODUCTIVE MEDICINE

SEMEN ANALYSIS REQUISITION

Patient Instructions: To schedule an appointment, please call either the Chicago or Highland Park clinic location and bring this requisition with you to the appointment.

PATIENT NAME: _____

DATE OF BIRTH: _____

WIFE/PARTNER: _____

DIAGNOSIS: MALE INFERTILITY/POST VASECTOMY/OTHER _____

REFERRING PHYSICIAN NAME: _____

REFERRING PHYSICIAN PHONE: _____

FAX NUMBER (FOR RECEIVING TEST REPORT): _____

REFERRING PHYSICIAN/DESIGNEE SIGNATURE: _____

DATE: _____

259 EAST ERIE STREET, SUITE 2400
CHICAGO, IL 60611
TEL 312.695.7269 FAX 312.472.4000

600 CENTRAL AVENUE, SUITE 333
HIGHLAND PARK, IL 60035
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