The Hewitt Fertility Centre Andrology Referral Form

Date of referral: _____

Patient details: Please attach patient label if available

Name:

Date of birth:

NHS no:

Mobile number:

Patient Address:

Where is the patient being referred from? Please tick appropriate box

GP surgery ☐ ACWH ☐ RLBUH ☐ ODGH ☐ SODGH ☐ Other_____

Details of referring clinician: Please use practice stamp if available

Clinician's Name:

Clinician's Address:
(Results will be posted here)

The patient has been informed that there will be a package sent to the address that they have given to us.

If ODGH or ACWH, please supply partner details Partner

Name:

Date of birth:

NHS no:

Address:

Appointment / Procedure required: Is the patient NHS ☐ or Private ☐

Fertility semen analysis ☐ (Ormskirk only – Pack given Y / N. Appointment date if known;_____)

Post vasectomy semen analysis ☐ Date Procedure performed_____

Post vasectomy reversal semen analysis ☐ Date Procedure performed_____

Sperm freezing ☐ (Please contact an Andrologist on 0151 702 4214 to confirm freezing request)

Additional information: e.g. Relevant clinical history, history of violence/aggression, viral risk, disability etc.

NB. If interpreter is required, please arrange once patient receives appointment date.

Please post or email this request form to:

Andrology Laboratory
Hewitt Fertility Centre
Liverpool Women's Hospital
Crown Street
Liverpool
L8 7SS
Tel No. 0151-702-4214
Email: lwft.andrologylab@nhs.net

PLEASE ENSURE THAT ALL DETAILS HAVE BEEN CORRECTLY COMPLETED.

YOUR PATIENT WILL THEN RECEIVE THEIR APPOINTMENT DATE & TIME, A COLLECTION POT AND ALL NECESSARY PAPERWORK & INSTRUCTIONS IN THE POST.

A TEXT MESSAGE REMINDER SERVICE WILL BE USED IF A MOBILE NUMBER IS SUPPLIED

Uncontrolled when photocopied.
Do not use after review date.