**There are three methods of referral:**

**Post to:** Appointment Centre, 163 Yardley Green Road, Birmingham, B9 5XS

**E-mail:** UHB-tr.appointments-centre@nhs.net

**eRS (Choose and Book – under Urology - Andrology - Male infertility, diagnostic semen analysis and investigations):** attach this form to the booking request *(eRS can currently only be used for routine diagnostic semen analysis – any other referral will need to be posted or e-mailed).*

|  |  |  |
| --- | --- | --- |
| **Andrology Patient Details** |  | **Type of Analysis required (please indicate):** |
| **Full Name:** |  | **Diagnostic Semen Analysis****Post Vasectomy Semen Analysis****Retrograde Analysis** | [ ] [ ] [ ]  |
| **Date of Birth:** |  |
| **Address:** |
| **Partner Details** **(Only required if part of Hospital Fertility Pathway, do not include if from a GP).** |
| **NHS/Hospital PID:** |  | **Full Name** |  |
| **Mobile Number:** |  | **Date of Birth** |  |
| **Additional Contact Information:** |  | **Hospital PID** |  |

**Referring Practitioner/GP Practice:**

|  |  |  |
| --- | --- | --- |
| **GP/Consultant Name:** |  | ***Practice/Clinic Stamp:*** |
| **Practice Address/Hospital Clinic:*****This must be completed for all GP referrals***  |  |
| **GP Practice Code:** |  |

**Other Information:**

|  |  |
| --- | --- |
| **Is there a known infection risk? If yes, give details.** |  |
| **Is there a known mental/physical impairment? If yes, please give details.** |  |
| **Does the patient require any support e.g. an interpreter? Please give details.** |  |
| **Is this the patient’s first sample?** |  |
| **Please indicate any clinical details relevant for the request (this is useful for all test requests especially retrograde).** |  |
| **Repeat Tests: state when the repeat is required clearly i.e. 3 months from date of referral/last test** |  |
| **POST VASECTOMY ONLY: What date was the operation?**  |  |
| **Signature**  |  | **Date** |  |