Andrology Laboratory Requisition Form

Diagnostic Andrology Laboratory
606 – 24th Avenue South, Suite 525
Minneapolis, MN  55454

For internal use:

Patient ID checked by: _______________________
Lab receipt time/date/initials: _______________________
Accession # :

Date: _______________________________________

Test requested:

☐ Semen analysis, strict morph
☐ Post-vasectomy analysis

☐ Semen analysis, estimated morph
☐ TESE (sperm ID)

☐ Semen analysis, no morph
☐ Cryopreservation of TESE

☐ Retrograde semen analysis
☐ Test thaw of cryo’d TESE

☐ Cryopreservation of sperm
☐ Antisperm Antibody testing

☐ Test thaw of cryo’d sperm
☐ ART processing

☐ Other: _______________________

Requesting physician/designee: _______________________

Diagnosis Code: _______________________________________

Clinic: _______________________________________

Clinic fax # :

Clinic phone # :

Male Patient I.D. Label (if no label, then patient name and either DOB or MR#):

Spouse/partner I.D. Label:

544971 Rev. 05/16