**For Semen analysis or cryopreservation**

# Semen Collection Instruction and Requisition Form

1. Semen Analysis appointments are at the **USF Health South Tampa Campus** (2 Tampa General Circle, 4th floor, Tampa, FL 33606) **from 9:30am to 11:00am on Tuesday, Wednesday and Friday.**
2. To book an appointment call **813-259-0692** for **scheduling** (press 2). Please let the scheduler know if you will be ***dropping off*** or ***collecting your specimen at our facility*** when you book the appointment. **MUST PROVIDE PHOTO ID AT TIME OF VISIT**.
3. You need to refrain from ejaculation by either intercourse or masturbation **for 2-5 days prior to the collection**. Shorter or longer periods of abstinence may cause abnormal results.
4. If you collect the semen at home, time from collection to dropping off should be no more than **60 minutes**.
5. If you do not have insurance coverage, the charge for the semen analysis is **$100**. Payment is due at the time of dropping off. Patients **with** insurance will have this test submitted by our Financial Specialist to their insurance carrier.
6. We recommend booking at least two weeks in advance.
7. Results will be obtained with your next Physician appointment

**Please use following instructions to collect your semen sample:**

1. Complete the information below.
2. Wash hands with alcohol wipes.
3. Clean your penis with the Alcohol-Prep (provided) and dry well.
4. **Produce sample by manual masturbation**.
5. Collect all semen in the specimen container provided.
6. Place lid back on the container, make sure lid is secure.
7. Place the label on the specimen container and place the container in a bag.
8. When completed please leave your sample in the collection room and alert the clinical person you are finished.

**Was entire specimen collected? Yes____ No____ Comments_____**

Today's Date: _____Date of last ejaculation: _____

Time of semen collected:_____ Your Physician:_____

Please print your name: _____ Date of Birth_____

Partner's name:_____ Date of Birth_____

**I verify that I am the below signed patient and that the sample I am turning over to the lab is my sample.**

Please sign your name:_____

**TO BE COMPLETED BY clinical area– DO NOT WRITE BELOW THIS SECTION**

**Identification Verification ID Type:** ☐ Driver's License ☐ Other _____

**Person Verifying:** _____

☐ Routine semen analysis ☐ Semen cryopreservation

Reviewed 1/31/11