



PHYSICIAN REFERRAL & CERTIFICATION FORM

Please complete the following form and keep a copy for your records.

Patient Information

Last Name	First	Middle	
Street Address	City	State	ZIP Code
Home Phone	Fax	Cell	Email

Reason for Sperm Banking: _____

Treatment Plan (please check all that apply):

- Surgery to the reproductive area, please explain: _____
- Radiation to the brain or reproductive area, please explain: _____
- Chemotherapy, please explain: _____
- Other, please explain: _____

Are there any known medical contradictions to the above-named patient undergoing sperm banking:

- Yes No if yes please explain: _____

Physician Information

Last Name	First	Middle	Degree
Title	State License Number	Practice or Hospital Name	
Street Address	City	State	ZIP Code
Phone	Fax	Email	Contact Name

I have examined this patient and find no contraindications to sperm banking. I have attached a copy of my History and Physical examination as well as a copy of the required blood tests to this form. The required blood tests include: HIV-1 and HIV-2 antibody (AIDS) tests, Hepatitis B surface antigen, and Hepatitis C antibody. These tests must have been taken 10 days prior to, or anytime after, the initial specimen was sent to New York Cryo for processing.

Physician Signature _____ Date _____