

REPROMED

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DONOR SEMEN SPECIMEN ORDER FORM

DATE OF REQUEST: _____

PHYSICIAN: _____

ADDRESS: _____

TELEPHONE: _____ FAX: _____

REQUESTED BY: _____

RECIPIENT NAME/ID: _____ DOB: _____

PATIENT STATUS WITH RML: NEW _____ CURRENT _____

DONOR CHOICE: (Please indicate all three choices)

1st:|_|_|_|_| 2nd:|_|_|_|_| 3rd:|_|_|_|_|

NUMBER OF VIALS: ___ PREPARATION: STANDARD ___ PREWASHED ___ IVF/ICSI: ___

DATE REQUIRED: ___ / ___ / ___
MM DD YY

SHIPPING DATE: ___ / ___ / ___
TO BE DETERMINED BY RML

ADDRESS: _____

CITY _____ PROV. _____ P.C. _____

HOME PHONE: _____ FAX: _____

WORK PHONE: _____ FAX: _____

MASTER CARD # _____ EXP. DATE _____

VISA # _____ EXP. DATE _____

NAME: _____

SIGNATURE: _____