Vasectomy Test Request

Patient Name: _____ Doctor: _____

Address: _____

Vasectomy Date: _____ Specimen Date: _____

Due Date: _____ Email Address: _____

Phone No.: _____ Cellphone No.: _____

☐ Yes, you can leave a message on my machine ☐ No, do not leave a message, email my results

Email Address: _____

☐ First Test (after 6 weeks and 15 ejaculations) ☐ Repeat Test

For Office Use Only

DT	P	/100HPF	R	F
T-1	PC			PC
T-2	LM	HPF		LM
T-3	EM			EM
T-4	PR	MOTILE		PR

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