ORIGIN

56 Aberfoyle Crescent, Suite 303, Etobicoke, Ontario M8X 2W4
Tel: (416) 233-8111, Ext 341 Fax: (416) 233-9180

DONOR SEMEN SPECIMEN ORDER FORM

DATE OF REQUEST: _____

TREATING PHYSICIAN: _____

CLINIC: _____

ADDRESS: _____

TELEPHONE: _____ **FAX:** _____

ORDER COMPLETED BY: _____

PATIENT NAME OR ID: _____ **DOB:** _____

PATIENT ORDERED FROM REPROMED PREVIOUSLY: YES _____ **NO**_____

DONOR CHOICE: (Please indicate all three choices if possible)

1st:|____|____|____|____| **2nd:**|____|____|____|____| **3rd:**|____|____|____|____|

NUMBER OF VIALS: _____ **PREPARATION:** ***UN-WASHED*** ____ ***WASHED*** ____ ***IVF/ICSI:*** ____

DATE VIALS NEEDED: _____/_____/_____
MM DD YY

SHIPPING DATE: _____/_____/_____
TO BE DETERMINED BY REPROMED

ADDRESS: _____

CITY _____ **PROV.**_____ **P.C.** _____

HOME PHONE: _____ **FAX:** _____

WORK PHONE:_____ **FAX:** _____

CREDIT CARD # _____ **EXP. DATE** _____

CVV (ON BACK) # _____

SEND RECEIPT BY: MAIL ____ **EMAIL** ____**, EMAIL ADDRESS:** _____

NAME: _____

SIGNATURE: _____

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