Dr.______________________________

5990 Côte-des-Neiges, Mtl, (Qc) H3S 1Z5
Tel: (514) 344-8022 Fax: (514) 344-8024
E-Mail: service@cdllabs.com
Monday to Friday from 8am to 8pm
Sunday from 10am to 2pm

SPERM ANALYSIS REQUISITION

☐ **STAT** Date (YYYY – MMM – DD) Lab ID # ____________ Reserved for CDL

Last Name ____________ First Name ____________ Medicare # ____________

Date of birth ____________ (YYYY – MMM – DD) Telephone # ____________ Dossier # ____________

Partner's Name (if applicable) ____________

SPECIMEN INFORMATION
(To be completed by patient)

Test requested ☐ Fertility (SPGMF) ☐ Post-vasectomy (SPGMPV)

Method of collection ☐ Coitus interruptus ☐ Masturbation

Time of collection ____________ (HH : MM) ☐ Specimen collected in sterile container (mandatory)

Time received at the laboratory ____________ (HH : MM) Days of abstinence ____________

COLLECTION PROBLEM
(To be completed by patient)

☐ Incomplete specimen ☐ None

☐ Other ____________

TRANSPORTATION PROBLEM
(Reserved for CDL)

☐ Exposure to temperatures < 20°C and/or > 37°C ☐ None

☐ Other ____________

Physician's Name ____________ License # ____________ Date ____________ Signature ____________