Dr. Kathleen Hoeger Dr. Erin Masaba Dr. Snigdha Alur-Gupta
Dr. John Queenan Dr. Wendy Vitek

Strong Fertility Center **500 Red Creek Dr., Suite 220, Rochester, NY 14623** **Phone: 585.487.3378**

Patient Name:_____ Date of Birth: _____
(Print Full Legal Name of Patient Collecting Semen Sample)

Partner Name:_____ Date of Birth: _____
(Print Full Legal Name of Partner, if Applicable)

Physician: (check the applicable box below)

Dr. S. Alur-Gupta Dr. K. Hoeger Dr. E. Masaba Dr. J. Queenan Dr. W. Vitek Dr. J.S. Gabrielsen Kriston Ward, NP

Jamie Feingold, NP Amanda Callanan, PA Lauren Heppner, FNP Other:_____

Medications/Supplements (within past 3 months):_____

Travel? If so, where and when: _____

Known exposure to COVID-19 or COVID-19 infection within the last 3 months? If so, when: _____

Days Since Last Ejaculation:_____

**********To be completed after sample collection **********

Time Specimen Collected:_____ AM PM

Were you able collect the entire sample in the provided sterile container? (Please check one) Yes No

If NO was checked, was the first part of the ejaculate lost? (Please check one) Yes No

I understand that this sample will be used for (Please initial at least one of the options listed below):

1 _____ Semen Analysis
Initial

2 _____ Semen Cryopreservation for (*Additional Consent Required):
Initial

Fertility Preservation Convenience banking (Back-up for IUI or IVF)

3 _____ IUI or IVF insemination procedure
Initial

BY SIGNING BELOW, I VERIFY THAT I AM THE PATIENT LISTED ABOVE AND THAT I AM SUBMITTING MY SEMEN SAMPLE TO STRONG FERTILITY CENTER FOR THE PURPOSE OF THE ASSISTED REPRODUCTIVE TECHNIQUE(S) LISTED ABOVE.

_____ _____
Signature of Patient Collecting Semen Sample Date

SAMPLE DROP OFF CONSENT


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