Laboratory Services
A Department of Rutland Regional Medical Center
Laboratory Phone: 802.747.1771

Semen Analysis Information Sheet

(To be completed by the Patient and submitted with the sample)

Patient Name: _____

Date of Birth: _____

Date of Collection: _____

Time of Collection: _____

Method of Collection: (Circle one) Masturbation | Other: (Please Specify Below)

_____

_____

Container: Sterile Cup

Number of Days of Abstinence: _____

Was the total volume collected? (Circle One) Yes | No

Did you keep the sample at body temperature when bringing it to the lab? (Circle One) Yes | No

If No, How was the sample transported to the lab?

_____

Spouse or Partner's name: _____