



SPAR - SPECIAL PROGRAM OF ASSISTED REPRODUCTION

A Program of the Bedford Research Foundation Clinical Laboratory
Massachusetts 501(c)(3) not for profit organization

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Billing

Laboratory

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CLIA # 22D0991667

TEST REQUISITION

Enclose one copy with your kit and keep one copy for your records

PATIENT INFORMATION

Last Name

First Name

Street Address

City

State

Zip

Phone

DOB

Female Name (required to label frozen sperm)

REFERRING PHYSICIAN (If Applicable)

Physician Name

Signature

Physician Address

Phone and Fax Number:

Signature

Kit Analysis or Service



Live Semen Transport Kit



Walk In Semen Collection Kit



Fixed Semen Kit



Complete Semen Analysis for Fertility Evaluation [89320]



Fractionation for Testing and Cryopreservation



Leukocyte Immunostain



Prostatitis Check - Bacterial Analysis



Viral Burden

Viral Test Requisition

If the sperm is suitable for freezing, I request that my semen specimen, submitted to the Bedford Research Foundation Laboratory on _____ be tested for the presence of HIV by the research test developed specifically for seme

Signature

Date

I agree do not agree that some data from these tests may be used in research studies without identifying me personally.

Signature

Date