PATIENT REFERRAL FORM

Date: _____

SpermCheck® VASECTOMY

Home Monitoring Program

Fax Completed Form to: **800-506-5461**

To be Completed by Clinic

Clinic		Phone		Urologist	Dr.

Physician Testing Protocol - To be Completed by Clinic (Please Check Box)

Validation #1: ☐ 45 Days (6 weeks) ☐ 60 Days (8 weeks) ☐ 90 Days (12 weeks) ☐ _____

Validation #2: ☐ 90 Days (12 weeks) ☐ 120 Days (16 weeks) ☐ _____

Special Instructions:

Patient Information - To be Completed by Patient

First Name		Last Name	
Date of Birth		Vasectomy Date	

Patient Cell Phone*		Alt. Phone	

Patient Email*			
Patient City		☐	Spanish Only
Patient Zip Code		☐	Other

***SpermCheck will contact you via email or text to collect your test results. Your email and text information will be kept confidential and will not be used or sold to a third party for marketing and sales purposes**

Please Report Your Results

www.RESULTS.SPERMCHECK.com or call **866-635-2309**

Patient Authorization - To be Completed by the Patient

By signing, you give your physician permission to release your information to SpermCheck® so a program consultant may contact you about ordering your SpermCheck® Vasectomy Tests as well as reporting your results. I agree to report my test results according to the protocol indicated below and understand that SpermCheck® will provide me with reminders prior to the scheduled test date.

Patient Signature		Date	

Patient Process

1. Once this form is received, **a representative from SpermCheck® will contact the patient** to order the required tests as outlined in the protocol. The patient may also order online at **www.SpermCheck.com**
2. The patient will perform test on dates corresponding to protocol. SpermCheck will provide reminders to patients of test dates.
3. Patient will report results to SpermCheck at **866-635-2309** or **www.RESULTS.SPERMCHECK.com**
4. SpermCheck will send patient test result report to clinic

If you have any questions, give us a call at **866-635-2308**