CANCELLATION OF SPERM STORAGE

Please complete this form and return via post or email to:

Department of Andrology & Sperm Bank
The Royal Women's Hospital
C/- Locked Bag 300, Parkville VIC 3052
Email: andrology.datamanager@thewomens.org.au

DETAILS OF PERSON WHOSE SPERM IS STORED				
FIRST NAME		LAST NAME		
ADDRESS			POSTCODE	
DATE OF BIRTH		AGE		
EMAIL		CONTACT NUMBER		

Please complete Section A or B, as appropriate:

SECTION A – PATIENT REQUEST			
I, ______________________________ (full name), **request cancellation of my sperm storage** and hereby authorise the Andrology Unit to destroy my stored sperm.			
SIGNED		DATE	

OR,

SECTION B – PARTNER / CHILD / NEXT-OF-KIN				
I, ______________________________ (full name), **wish to notify you that my partner / child / next-of-kin (please circle) is deceased** and I hereby authorise the Andrology Unit to destroy their stored sperm.				
SIGNED		DATE		
YOUR ADDRESS			POSTCODE	
YOUR CONTACT NUMBER		YOUR EMAIL		
IMPORTANT: If completing Section B, please include a copy of your partner/child/next-of-kin's death certificate.				

OPTIONAL – VOLUNTARY DONATION OF SAMPLE TO RESEARCH *(please complete IN ADDITION to Section A or B)*			
I,______________________________(full name) **give permission** to the Andrology Unit for my specimen to be used anonymously for research, teaching and quality assurance purposes.			
SIGNED		DATE	