

Department of Andrology
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REQUEST FOR TRANSFER OF FROZEN SPERM

I hereby authorise the Andrology Unit of The Royal Women's Hospital to arrange the transfer (please indicate *one*:) all / ____ (number) frozen sperm straws/vials.

PATIENT INFORMATION			
FIRST NAME			
LAST NAME			
DATE OF BIRTH	MOBILE NUMBER		
ADDRESS			
SUBURB	POSTCODE		
EMAIL			
TRANSFERRING FRO	ZEN SAMDI ES EDOM:		
TRANSFERRING FROZEN SAMPLES FROM: CLINIC NAME			
CLINIC ADDRESS			
CONTACT NAME	CONTACT NUMBER		
CONTROL NAME			
TRANSFERRING FROZEN SAMPLES TO:			
CLINIC NAME			
CLINIC ADDRESS			
CONTACT NAME	CONTACT NUMBER		
AUTHORISATION			
In making this request I absolve The Royal Women's Hospital and any of its Servants and Agents, and particularly the staff of the Andrology Unit, of any liability for loss of, or damage to my sperm during the transfer process. I also agree to pay for the cost of the transfer of my sperm.			
SIGNED	DATE		
WITNESS	DATE		
WITNESS FULL NAME			

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