Washington University in St. Louis
Physicians

Fertility & Reproductive Medicine Center

Sperm Banking

Option to fill out electronically and print
Please sign names with pen

- Sperm Banking Procedures 1-2
- Patient Information 3
- Patient Consent 4-5
- Consent to release information 6
- Authorization for medical treatment & financial responsibility..... 7-8

Please bring forms (filled out & signed) with you to your appointment.

Thank you

Sperm Banking Procedures

Fertility and Reproductive Medicine Center
Washington University Physicians and Barnes-Jewish Hospital

The Fertility and Reproductive Medicine Center at Washington University provides a semen preservation service for patients who wish to have their semen preserved in a frozen state (cryopreservation) for future infertility treatments of a spouse or domestic partner. There are a variety of medical indications where this procedure is used including prior to cancer therapy, prior to specific surgeries, or due to low sperm counts.

What is Cryopreservation?
Cryopreservation is a medically accepted method of maintaining semen for future artificial insemination or in vitro fertilization (IVF). The procedure consists of collecting, freezing, and storing semen until requested for release. Upon the patient's request, the stored semen specimens are thawed and released for use in artificial insemination or IVF in accordance with the guidelines established by the American Society for Reproductive Medicine.

Am I a Candidate?
Semen cryopreservation services are available for men who anticipate future infertility for physical or medical reasons or who may be unable to provide fresh semen at the optimal time for artificial insemination or IVF. The Fertility and Reproductive Medicine Center offers cryopreservation on a one time, periodic or regular basis in combination with fertility services provided by this Center.

Semen Collection
It is very important that all of the semen specimens be collected and processed under optimal conditions. This includes a minimum 48 hours of sexual abstinence. We have private rooms available for specimen collection at the doctor's office. Lubricants of any type should not be used during the collection process. If you cannot collect the specimen at our facility, the specimen needs to arrive at the doctors' office within one hour of collection. Specimen containers may be picked up at our office in advance of the banking appointment. If the outside temperature is below 70 degrees Fahrenheit the specimen should be kept next to your body, so that the sample's temperature remains optimal. All initial specimens received by the laboratory must be accompanied by the forms in this packet before the samples are processed. These forms are provided to patients when they check in at our office and they are also available on our website at fertility.wustl.edu.

To bank specimens:

Please call	(314) 286-2431
Appointment times	Monday - Friday between 9 a.m. and 11 a.m.
Day of your appointment	Please go to the Fertility and Reproductive Medicine Center at Washington University, 4444 Forest Park Avenue, Suite 3100. In the doctors' office, you will first meet the receptionist, who will accept payment and then direct you to the appropriate location.

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Freeze-thaw Analysis

The freezing of sperm is a highly technical procedure. Unfortunately, the cryopreservation process may lead to deleterious effects on sperm viability and function. Consequently, the first step in banking is to complete a freeze-thaw analysis to analyze how well the sperm survives processing. The lab will run a semen analysis on the initial specimen, freeze the specimen, thaw a small portion, and run a semen analysis on the post-thaw sample. The results of this analysis can then help physicians make recommendations for banking and possible use of the samples in the future.

For the results of the initial freeze-thaw analysis, please call your reproductive endocrinologist (fertility specialist) to schedule an appointment for a consultation visit. At the consultation, the physician will discuss the freeze-thaw analysis results, methodologies for use of banked specimens in order to achieve pregnancy, and recommendations for future banking based upon the patient's individual situation.

Screenings

All patients who desire to proceed with sperm banking must be screened for HIV 1, HIV 2, Hepatitis B surface antigen, Hepatitis C antibody, and RPR prior to any samples being accepted into the laboratory for processing. The FDA does not require separate storage for specimens that have had additional infectious disease testing however these five tests are a required minimum. If any of these tests were run at another facility and will not be completed prior to banking for emergent circumstances, these tests will be rerun at our facility and the patient will be responsible for any additional fees. In the event that any of these screens are found to be positive, the patient will not be a candidate for banking in our laboratory.*

* Patients who are positive for one or more of the required infectious disease tests may choose to cryopreserve semen at our facility. However, arrangements must be made in advance by the patient for shipment and long term storage of the specimen(s) at an outside storage facility equipped to handle semen specimens from infected individuals.

Semen Analysis & Storage

A semen analysis will be performed on every specimen deposited. Each specimen will be divided into separate vials for frozen storage. The number of vials per specimen depends upon an individual patient's initial volume with a range typically between 2 and 8 vials per specimen. Specimens banked for storage greater than 6 months are subject to a yearly storage fee. A notarized discard form will need to be completed by the patient and sent to the Andrology lab in order to discontinue storage services. Patients wanting to bank their specimen long term will need to arrange to have the specimens shipped to a site that offers long term storage; we will provide information on these companies.

In the event of a patient's death, semen shall only be released pursuant to the patient's authorized consent in accordance with the information listed in the signed "Semen Preservation/ Cryopreservation Patient Consent" form. In the event that a patient has not declared a recipient, the Fertility and Reproductive Medicine Center shall properly dispose of the patient's semen specimens.

For further information about Sperm Banking, please call us at 314-286-2431.

Semen Preservation/Cryopreservation Patient Information

Fertility and Reproductive Medicine Center (FRMC) - Andrology Laboratory
Washington University Physicians and Barnes-Jewish Hospital

Client Depositor's Name _____ Date of Birth _____

Permanent Address - Street _____ City _____ State _____ Zip _____

Email Address _____ Phone Number _____

Partner's Name _____ Date of Birth _____

Emergency Contact Name _____ Phone Number _____

REASONS FOR SEMEN STORAGE: (check all that apply)

☐ Prior to Cancer Treatment (please provide type of cancer and type of treatment)

Type of Cancer: _____ Start Date & Time: _____

Type of Treatment:

☐ Chemotherapy ☐ Both Chemo and Radiation Therapy

☐ Radiation Therapy ☐ Bone Marrow Transplant

Name of Oncologist and Contact Information: _____

_____

☐ Banking for IVF/Back up for Fresh Collection

☐ Known Donor (not spouse or intimate partner)

☐ Testicular biopsy or aspiration/epididymal aspiration

☐ Prior to Surgical Procedure (check type below)

☐ Varicocele Repair ☐ Orchiectomy

☐ Prostate Surgery ☐ Back Surgery

☐ Other _____

☐ For Use by Partner While Away/Traveling

☐ Banking for IVF/Low Count

☐ Transgender Surgery and/or Therapy

☐ Pre-Vasectomy

Semen Preservation/Cryopreservation Patient Consent

Fertility and Reproductive Medicine Center (FRMC) - Andrology Laboratory
Washington University Physicians and Barnes-Jewish Hospital

I, _____ (DOB:_____) having been advised of and having considered the various alternatives to attempting to conceive children through natural means, adoption, or continuing to live without children, have decided to store my semen with the Fertility and Reproductive Medicine Center at Washington University (FMRC) for future infertility treatments. I hereby acknowledge that I have read and reviewed the "Sperm Banking Procedures" form provided by the FRMC _____ (please initial). As a result, I understand the procedures for sperm cryopreservation and my responsibilities and obligations associated therewith.

I understand that my serum will be screened for sexually transmitted diseases, including HIV, Hepatitis B, Hepatitis C, and RPR. An initial semen specimen will be collected, analyzed, frozen, thawed, and examined to assess the potential usefulness of the cryopreserved specimen. Based on this information the FRMC will discuss the utility of the cryopreserved semen specimen with me. I understand the FRMC may advise against or deny cryopreservation based on the results of the patient's medical or personal history, patient consultation, screening or semen analysis results.

I acknowledge my responsibility for all cryopreservation charges, including professional and laboratory charges, storage charges if the semen specimen is not discarded or released, and any additional handling, packaging, and shipping charges for specimens if released. I understand that the FRMC cannot provide long-term storage of my semen or testicular tissue. I understand that if I desire long-term storage (greater than 12 months) of my samples, it is my responsibility to contact a facility that provides long-term specimen storage. I also understand that to discard/discontinue storage of my semen specimen I must complete a semen specimen discard form and mail it to the Andrology Lab at the FRMC. The signature on all mailed forms must be notarized. If returning the form at the FRMC I must bring a valid photo ID for signature verification. The FRMC shall properly dispose of all patient semen specimens for which services have been discontinued. The FRMC shall discontinue cryopreservation for patient accounts remaining overdue for 12 months.

I understand that the FRMC makes no assurances or guaranties that any specimen preserved is suitable or acceptable for successful infertility treatments. I also understand that The FRMC further makes no assurances or guaranties that any infertility treatments using semen specimens stored by the FRMC shall result in pregnancy or that any pregnancy or child conceived shall be carried to full term. I understand that the FRMC further makes no assurances or guaranties that any child born as a result of infertility treatments using my cryopreserved semen specimens shall be free from illness, genetic defect, handicap, or disease, nor that any such child born shall be without abnormality, or free from undesirable traits or hereditary tendencies, or without any other diseases, problems or disabilities of children conceived by natural means. The FRMC will make efforts to maintain the environment of the tissue but cannot be held responsible for the loss of viability due to natural disasters or other emergencies beyond the control of the clinic. Specimens may be moved to an alternate location in an emergency situation.

Semen Preservation/Cryopreservation Patient Consent

Fertility and Reproductive Medicine Center (FRMC) - Andrology Laboratory
Washington University Physicians and Barnes-Jewish Hospital

All patient medical records, including patient consultations, patient medical and personal histories, screening and semen analysis results, shall be treated as confidential and shall be maintained by the FRMC in accordance with applicable guidelines for the maintenance of medical records. Such medical records are subject to release only as required by law or with the patient's consent.

I hereby allow the FRMC to obtain the necessary blood and semen samples and to perform all the necessary tests and analysis on such samples. If such tests and analysis are acceptable to FRMC at Washington University, I agree to allow FRMC at Washington University to preserve my semen by cryopreservation, as described in the "Sperm Banking Procedures" forms. If the results of such tests and analysis are unacceptable to FRMC at Washington University, I agree to allow FRMC at Washington University to properly dispose of my semen specimens.

Please choose and sign one of the following:

Unless otherwise specified (see below), I want FRMC at Washington University to properly dispose of my semen specimens in the event of my death.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

OR

In the event of my death, I appoint (name) _____ (DOB: _____)
my _____ (relationship) as the designated recipient to receive my semen specimens for the sole purpose of infertility treatments. I understand that if the designated recipient is other than my spouse or sexually intimate monogamous partner, that specimens will only be released if all appropriate disease screening has been completed (i.e. rescreening after six months quarantine and completion of testing procedures as required to be a sperm donor).

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

Consent To Release Information

Fertility and Reproductive Medicine Center
Washington University Physicians and Barnes-Jewish Hospital

Patient

I, _____ , hereby authorize the Fertility and Reproductive Medicine Center at Washington University School of Medicine and Barnes-Jewish Hospital staff to discuss my medical treatment (including test results) as follows (*check all that apply*):

- ☐ Leave message at home
- ☐ Leave message at work
- ☐ Leave message on cell phone # _____
- ☐ Discuss medical treatment with my spouse/significant other
- ☐ Discuss medical treatment with my parent
- ☐ Discuss medical treatment with: _____

Spouse/Significant Other

I, _____ , hereby authorize the Fertility and Reproductive Medicine Center at Washington University School of Medicine and Barnes-Jewish Hospital staff to discuss my medical treatment (including test results) as follows (*check all that apply*):

- ☐ Leave message at home
- ☐ Leave message at work
- ☐ Leave message on cell phone # _____
- ☐ Discuss medical treatment with my spouse/significant other
- ☐ Discuss medical treatment with my parent
- ☐ Discuss medical treatment with: _____

I understand that it is my responsibility to inform the office if any of the above directives change.

_____ _____
Patient Name Date

_____ _____
Spouse/Significant Other Name Date

Fertility and Reproductive Medicine Center
Suite 3100, 4444 Forest Park Ave., St. Louis, MO 63108
Phone: (314) 286-2465 • Fax: (314) 286-2455

BARNES-JEWISH Hospital
BJC HealthCare

Washington University in St. Louis
Physicians

NATIONAL LEADERS IN MEDICINE

AUTHORIZATION FOR MEDICAL TREATMENT AND FINANCIAL RESPONSIBILITY

ADDRESSOGRAPH

1. CONSENT

I authorize my physician and other physicians who may attend me, their assistants, including those employed by the Washington University School of Medicine (herein after referred to as "WU"), and Barnes-Jewish Hospital (herein after referred to as "Hospital"), its house staff, employees, and students to provide the medical care, tests, procedures, drugs, blood and blood products, services and supplies considered advisable by my physician. These services may include pathology, radiology, emergency services and other special services ordered by my physician(s). In consenting to treatment, I have not relied on any statements as to results. I further authorize my physician or Hospital staff to examine, use, store, and/or dispose of in any manner (except for organ donation and/or transplantation) any bones, organs, tissue, fluids or parts removed from my body.

In the event that any personnel assisting in the provision of care and treatment suffer inadvertent exposure to any of my blood and/or other bodily substances that are capable of transmitting disease and I am unable to consult timely with my physician prior to testing, I consent to limited testing to determine the presence, if any, of antibodies to hepatitis A, 8, and C and HIV.

2. STORAGE AND RELEASE OF INFORMATION

I consent to the electronic storage and transmission of patient health information. l hereby authorize my treating physician, WU and Hospital and its affiliates, to release by electronic means or otherwise any medical and/or billing information concerning my care, including copies of my medical records, to the following:

1. Any governmental or other entity as required by law for purposes of reporting, or for purposes of determining eligibility in government sponsored benefit programs.
2. The supplier of any blood or blood products which may be administered to me for the purposes of quality control and recipient monitoring.
3. Any continuing care, residential, or long-term care facility, or home health agency for the purposes of providing services for my care.

3. MEDICARE/TRICARE INSURANCE BENEFITS

I certify that the information given by me in applying for payment under the Title XVIII of the Social Security Act is correct. I authorize the release of medical or other information to the Medicare Program or its Intermediaries or carriers concerning this or a related claim filed by the Hospital or WU. I request that payment of authorized benefits be made on my behalf. I understand that I am responsible for the Part B deductible for each year and/or visit, the remaining co-insurance and any other non-covered personal charges.

I (or my representative) certify(ies) that I (or he/she) have read (or if the patient/representative is unable to read has had the form read to him/her) and understand(s), accepts(s) the above and further certify that I am the patient, or am duly authorized on behalf of the patient to execute such an agreement.

BARNES-JEWISH Hospital BJC HealthCare | Washington University in St. Louis Physicians

NATIONAL LEADERS IN MEDICINE

AUTHORIZATION FOR MEDICAL TREATMENT AND FINANCIAL RESPONSIBILITY

ADDRESSOGRAPH

4. GUARANTEE FOR PAYMENT

In accordance with the above terms and in consideration of the services provided to the above-named patient by WU and/or the Hospital, the undersigned agrees, whether he/she signs as patient or-guarantor, to pay WU, physicians and the Hospital for all services ordered by the attending physician, or requested by the patient and/or the patient's family. If the requirements for referral, second opinion or pre-certification of care, as outlined by my insurer, benefit plan or other payer, have not been followed, the patient and/or guarantor may in some instances be personally responsible for all charges incurred.

5. ASSIGNMENT OF INSURANCE BENEFITS

In consideration of any and all medical services, care, drugs, supplies, equipment and facilities furnished by WU, all attending physicians and Hospital, I authorize direct payment to WU and/or the Hospital of all insurance benefits applicable to these medical and other services, which are now or which shall become due and payable to me. In addition, I hereby authorize payment to the Hospital of applicable insurance benefits for medical and/or surgical services rendered by physicians for whom the Hospital is authorized to bill and collect.

HIPAA - Notice of Privacy Practices Acknowledgement

I acknowledge that I have received or I have been provided the opportunity to receive a copy of the "Notice of Privacy Practice" that explains when, where, and why my confidential health information may be used or shared. I acknowledge that WU, the physicians, the nurses and other University staff may use and share my confidential health information with others in order to treat me, in order to arrange for payment of my bill and for issues that concern WU operations and responsibilities.

Initials of patient or person authorized to sign HIPAA Notice for patient. _____

Signature of patient or person authorized to consent	Date	Patient's relationship to person	
Signature of Guarantor	Date	Patient's Relationship to Guarantor	
Signature of Witness	Date		