



Fertility and Reproductive Medicine Center

Sperm Banking

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

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

Sperm Banking Procedures

WashU Medicine Fertility and Reproductive Medicine Center

The WashU Medicine Fertility and Reproductive Medicine Center 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 use or disposal. 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?

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. In the event that any of these screens are found to be positive, the patient will not be a candidate for storage in our laboratory.* The FDA does not require separate storage for specimens that have had additional infectious disease testing; however, these five tests are a required minimum.

Semen Collection

It is very important that all of the semen specimens be collected and processed under optimal conditions. This includes a minimum of 48 hours of sexual abstinence. We have private rooms available for specimen collection in our facility. 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 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 a "Cryopreservation Patient Information Form" and a "Semen Preservation/Cryopreservation Patient Consent Form" before the samples are processed. These forms are provided to patients when they check in at our office.

To bank specimens:

Please call	314-286-2400
Appointment times	Tuesday - Friday at 10:20 a.m.
Day of your appointment	Please go to the WashU Medicine Fertility and Reproductive Medicine Center, 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.

Sperm Banking Procedures

WashU Medicine Fertility and Reproductive Medicine Center

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.

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. In the event that any of these screens are found to be positive, the patient will not be a candidate for storage in our laboratory.* The FDA does not require separate storage for specimens that have had additional infectious disease testing; however, these five tests are a required minimum.

* 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. Patients will be responsible for any additional charges.

Semen Analysis and Storage

A partial 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 are subject to a monthly storage fee of \$45. A notarized discard form will need to be completed by the patient and sent to the Andrology lab in order to discontinue storage services. The patient also has the option to come into the office with their photo ID and sign the disposition form [here](#).

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.

Sperm Preservation/Cryopreservation Patient Information

WashU Medicine Fertility and Reproductive Medicine Center – Andrology Laboratory

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 and Time: _____

Type of Treatment:

- Chemotherapy Both Chemo and Radiation Therapy
 Radiation Therapy Bone Marrow Transplant

Banking for IVF/Back up for Fresh Collection For Use by Partner While Away/Traveling

Known Donor (not spouse or intimate partner) Banking for IVF/Low Count

Testicular biopsy or aspiration/epididymal aspiration HRT/Gender Affirming Care

Prior to Surgical Procedure (check type below) Pre-Vasectomy

- Varicocele Repair Orchiectomy
 Prostate Surgery Back Surgery
 Other _____

Sperm Preservation/Cryopreservation Patient Information

WashU Medicine Fertility and Reproductive Medicine Center – Andrology Laboratory

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 WashU Medicine Fertility and Reproductive Medicine Center (FRMC) 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. Storage is charged monthly and is subject to change. FRMC has the right to relocate specimen to an outside facility. I also understand that to discard/discontinue storage of my semen specimen, I must complete a semen specimen discard form and MyChart, e-mail, or 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.

I understand that the FRMC makes no assurances or guarantees that any specimen preserved is suitable or acceptable for successful infertility treatments. I also understand that the FRMC further makes no assurances or guarantees 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 guarantees 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.

Sperm Preservation/Cryopreservation Patient Information

WashU Medicine Fertility and Reproductive Medicine Center – Andrology Laboratory

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 WashU Medicine FRMC, I agree to allow WashU Medicine FRMC 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 WashU Medicine FRMC, I agree to allow WashU Medicine FRMC to properly dispose of my semen specimens.

Please choose and sign one of the following:

Unless otherwise specified (see below), I want WashU Medicine FRMC 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).

Recipient will be responsible for paying storage charges.

Please attach Living Will or notarized document stating recipient is aware of the
arrangement.

Patient Signature

Date

Witness Signature

Date

Consent to Release Information

WashU Medicine Fertility and Reproductive Medicine Center – Andrology Laboratory

Patient

I, _____, hereby authorize the WashU Medicine Fertility and Reproductive Medicine Center 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 WashU Medicine Fertility and Reproductive Medicine Center 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
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