Fairfax Cryobank

Medical and Genetic Tests for Client Depositors

Listed below are tests routinely performed on individuals who would like to have their reproductive tissue stored at Fairfax Cryobank Inc. (hereafter referred to as "Cryobank") for fertility procedures. All clients having semen frozen by Cryobank are required to have current testing for HIV-1 and HIV-2 antibody, Hepatitis B surface antigen, and Hepatitis C antibody. If specimens are to be banked or used in the state of California, HTLV I/II and Syphilis testing is also required. Each test and the respective cost is listed below and will be charged in addition to the normal freezing, storage, shipping and handling fees listed on the fee schedule.

Required for ALL Client Depositors		
☐	I will provide Cryobank a copy of the lab report and test results for the above-mentioned required tests within 15 days. I understand that these tests must have been performed in the last 30 days. I am responsible for any charges incurred by the outside testing source. Failure to comply will result in my samples being placed into quarantine until the test results have been received. While the samples are in quarantine, I understand that I will be charged the current monthly quarantine storage fee.	$0
☐	I would like my blood drawn onsite and tested for the appropriate diseases as per current testing regulations for the standard Client Depositor Program	$140

You may choose additional testing in the table below, please indicate desired testing with a check mark.

Optional Testing, please indicate desired testing below		
Serology		
☐	FTA	$90
☐	HIV-1, HIV-2, HBV & HCV by PCR	$300
☐	Blood group & Rh type	$50
☐	*West Nile Virus	$105
☐	Other	Variable
Semen Specimen Tests by PCR		
☐	Cytomegalovirus NAT	$250
☐	Human Papilloma Virus (HPV16 & HPV18)	$500
☐	Herpes Simplex Virus (HSV1 & HSV2)	$500
Genetic Testing		
☐	Karyotype (blood chromosome analysis)	$500
☐	Individual Genetic Disease:	$250
☐	Expanded Carrier Panel (500+)	$500

*WNV testing is recommended for specimens collected between June 1 and October 31.

I authorize Cryobank to follow the directions in the boxes checked above regarding genetic and disease testing and perform the blood tests(s) on the individual from whom semen is to be obtained, frozen, and stored. I also understand that Cryobank or its personnel are in no way responsible for the results of any subsequent inseminations performed with the semen specimens I have requested to be screened and cryopreserved.

Client Name (please print): _____

Client Signature: _____ Date _____

Reviewed by Cryobank Staff (Signature): _____ Date _____