

Medical and Genetic Tests for Client Depositors

GENERAL INFORMATION:

Listed below are tests routinely performed on men who would like to have their reproductive tissue stored at Fairfax Cryobank (hereafter referred to as "Cryobank") for fertility procedures. **All patients having semen frozen by Cryobank are required to have current HIV-1 and HIV-2 antibody (AIDS) tests, Hepatitis B surface antigen, and Hepatitis C antibody tests.**

If you intend to have semen specimens frozen and stored by Cryobank, you must designate which tests you wish to have performed on the individual from whom the semen specimen will be obtained. **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.**

DIRECTIONS:

1. Check one of the boxes listed below:

- ☐ 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.**
- ☐ I want the **following tests (required to be included)** performed on the individual from whom semen is to be obtained. HIV-1 & 2 Ab, Hep Bs Ag, and Hep C Ab.

Please initial: _____ (Client Depositor) _____ (Cryobank)

2. If you would like any additional testing that was not included in the above, please select from below and check one of the boxes:

- ☐ In addition to the required tests (HIV-1 & 2 Ab, Hep Bs Ag, and Hep C Ab), I **do** want the additional tests checked below performed on the individual from whom semen is to be obtained.
- ☐ I have been informed that all of the below tests are routinely completed on Cryobank semen donors and I do **not** want any of the additional tests listed below performed.

Please initial: _____ (Client Depositor) _____ (Cryobank)

SEROLOGY:

- | | |
|---|-------------|
| <input type="checkbox"/> HIV-1, 2, & O antibody | \$70.00 |
| <input type="checkbox"/> HIV-1, HBV & HCV by PCR | \$300.00 |
| <input type="checkbox"/> Blood group & Rh type | \$50.00 |
| <input type="checkbox"/> Hepatitis B surface antigen | \$35.00 |
| <input type="checkbox"/> Hepatitis C antibody | \$35.00 |
| <input type="checkbox"/> Hepatitis B core antibody | \$50.00 |
| <input type="checkbox"/> CMV antibody | \$50.00 |
| <input type="checkbox"/> Syphilis | \$50.00 |
| <input type="checkbox"/> HTLV-I/II antibody | \$100.00 |
| <input type="checkbox"/> Chlamydia & Gonorrhea | \$200.00 |
| <input type="checkbox"/> SGOT | \$21.00 |
| <input type="checkbox"/> SGPT | \$21.00 |
| <input type="checkbox"/> West Nile Virus by NAT* | \$52.00 |
| <input type="checkbox"/> Other _____ | \$ _____.00 |

FINISH COMPLETING FORM ON PAGE 2

Account # _____

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SEMEN SPECIMEN TESTS BY PCR TECHNOLOGY (Tests performed on semen):

<input type="checkbox"/> Cytomegalovirus NAT	\$250.00
<input type="checkbox"/> Human Papilloma virus (HPV16 &18)	\$500.00
<input type="checkbox"/> Herpes Simplex virus (HSV1 &2)	\$500.00

GENETIC TESTS

<input type="checkbox"/> Karyotype (blood chromosome analysis)	\$531.00
<input type="checkbox"/> Cystic Fibrosis (DNA based test for carrier of gene mutation)	\$299.00
<input type="checkbox"/> Sickle cell anemia (African American descent)	\$146.00
<input type="checkbox"/> Tay-Sachs Biochemical	\$130.00
<input type="checkbox"/> Thalassemia (Mediterranean descent)	\$146.00
<input type="checkbox"/> HLA Phenotype with DQ alpha	\$725.00
<input type="checkbox"/> Jewish Panel (List available upon request)	\$2,760.00

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

I authorize Cryobank to follow the directions in the boxes checked above (or on page 1) regarding genetic and disease testing, and perform the 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): _____

Account Number: _____ (assigned by Cryobank)

Client Signature: _____ Date _____

Reviewed by Cryobank Staff (Signature): _____ Date _____