HELSE BERGEN Haukeland universitetssjukehus	Begjæring om utlevering av eigne lagra spermier (eigentransport) ENGELSK
Kategori: Pasientbehandling/Pasientadministrasjon	Gyldig fra/til:02.05.2023/02.05.2024
Organisatorisk plassering: Helse Bergen HF/Kvinneklinikken/Fertilitetssenteret	Versjon: 4.00
Godkjenner: Siren Skrede	Avtale
Dok. ansvarlig: Siren Skrede	Dok.id: D48082

The sperm bank at Haukeland University Hospital is a diagnostic and treatment biobank. The stored material shall be used for future assisted reproduction treatment for the spouse or co-habiting partner of men who must undergo medical treatment that may affect fertility or who, for various medical reasons, have a non-existent or substantially impaired ability to produce fresh semen samples of sufficient quality.
The material may only be used for treatment approved in Norway, in line with the Biotechnology Act and by couples who meet the Norwegian assisted reproduction requirements.

The institution/clinic where treatment is to take place must be approved under the Regulations on the quality and safety requirements for handling human cells and tissue.

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1. To be filled out by patient

The undersigned has ____ straws stored in the sperm bank at the Unit for Assisted Reproduction and wishes to withdraw _____ straws.

The undersigned hereby requests withdrawal of his own frozen sperm for the purpose of assisted reproduction treatment and assumes full responsibility for the material during transport to the recipient location. The undersigned must show ID at collection.

When borrowing transport containers from the Unit for Assisted Reproduction at the Women's Clinic, Haukeland University Hospital, the undersigned assumes responsibility for returning any such containers to the Unit as soon as possible and in the same condition as when received. The Unit for Assisted Reproduction at the Women's Clinic, Haukeland University Hospital, does not assume any responsibility for the material once it has left the Unit.
The undersigned is familiar with the terms for use of the material and hereby requests withdrawal of his own frozen sperm for the purpose of assisted reproduction treatment.

Name:

Norwegian personal identification number (11 digits):

Date:……. Signature:……..

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2. To be filled out by the receiving clinic

The undersigned is aware of the terms and conditions for use of the material for the aforementioned patient.

Institution/clinic at which treatment is to take place:…….
(The Institution must be approved under the Regulations on the quality and safety requirements for handling human cells and tissue, or a corresponding regulatory framework, cf. above)

Date:……. Signature:……..
Treating physician

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3. To be filled out by the attending physician/Unit physician, The Unit for Assisted Reproduction, HUS:

Approval of request for withdrawal

Date:……. Signature:……