Request for Endometrial Function Test® (EFT®)

Physician: ______________________________
Location: ______________________________
Contact: ______________________________
Telephone: ______________________________
Fax: ______________________________
Cell: ______________________________
email: ______________________________

Please fill out **one** form **per** biopsy.

Please only send biopsies Monday through Thursday via FedEx Express **Priority Overnight** to:

Harvey Kliman, MD, PhD
Reproductive and Placental Res Unit
Department of Obstetrics & Gynecology
310 Cedar Street, FMB 225
New Haven, CT 06510

Ordering M.D. Signature ______________________ ***Date*** __________ **K2**____ – ________
↑ Office Use Only ↑

Patient Name ____

Date of Birth __________ **Principal Diagnosis** ______________________________

G ___ **P** ____ **SAb** ____ **Biochem** ____ **Elec Ab** ____ **Prem** _____ **Ectopic** ____ **Liv** _____

Failed IVF-ET (#) ____ **Failed FET (#)** ____ **Failed Donor ET (#)** ____ **Failed IUI (#)** ____

LNMP __________ ****Date LH Surge**** ______________________

Blood type, if known ________ **Male factor present?** ______________________

Will be securely shredded

Date of Biopsy ______ **Clin cycle day** _____ **(urine LH surge = d13, first full day P = d14)**

Diagnoses from prior biopsies? ______________________________

Weight _____ **Height** ____ **BMI** ____ **Cycle:** **Natural** ❐ **Mock** ❐ **Stimulated** ❐

If mock or stimulated cycle, please fill out the following: **Suppression:** __________

E2: **Route** _____ **Start date** ________

P: **Route** _____ ****Start date**** ________ ❐ AM ❐ PM

****Please always try to fill in at least one of the boxed dates****

Other medications, additional relevant clinical information, or specific questions:

❐ H&E ($50) to rule out Quantity Not Sufficient (if adequate, EFT is performed the next week)

☞☞☞ **I understand that I am personally and fully responsible for payment of the fee for this test.**
***** No discount will be accepted based on insurance coverage. *****

Required Patient Signature ______________________________ ***Date*** __________

Credit card ($595): VISA **or** MasterCard **Name on card:** __________________ **Tel#:** __________

Card number: ______________________________ **CVV:** ______**Exp:** mm | yy

House Number & Street: ______________________ **State/Province:** __________

City: ______________________________ **Zip or postal code:** __________