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*** _____ **K1____ – _____**

↑ 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?** _____

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)

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:** _____

☞☞☞ 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*** _____