

# Request for Endometrial Function Test<sup>®</sup> (EFT<sup>®</sup>)

Physician: \_\_\_\_\_ Please fill out **one** form **per** biopsy.  
Location: \_\_\_\_\_ Please only send biopsies Monday  
Contact: \_\_\_\_\_ through Thursday via **FedEx Express**  
Telephone: \_\_\_\_\_ **Priority Overnight** to:  
Fax: \_\_\_\_\_ Harvey Kliman, MD, PhD  
Cell: \_\_\_\_\_ 375 Congress Avenue, LSOG 406  
email: \_\_\_\_\_ Yale University School of Medicine  
New Haven, CT 06519

**\*\*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 (\$459):**  or  **Card holder Tel#:** \_\_\_\_\_

**Name on card:** \_\_\_\_\_ **Card number:** \_\_\_\_\_ **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** \_\_\_\_\_