VERITAS
FERTILITY & SURGERY

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# EndoSure Test Referral Form

Date of Referral: _____

Referring physician: _____

Practice name: _____

Office phone: _____

Office fax: _____

endosure TEST

Patient name: _____

Patient DOB: _____

Patient phone: _____

Patient email: _____

Reason for referral (check any that apply):

- ☐ Pain
- ☐ Recurrent pregnancy loss
- ☐ Infertility
- ☐ Heavy/abnormal bleeding
- ☐ Other: _____

When referring a patient to Veritas Fertility and Surgery for the EndoSure Test, please complete and fax this form to 314-405-9557. The results of the test will be returned by fax within 3-5 business days with an interpretive report.

LEARN MORE » veritasfertility.com/endosure