SPRING FERTILITY

Fertility Consult Referral

newpatients@springfertility.com
p. (646) 568-5638

New York City Clinic / Lab

114 W 41st Street, 2nd Floor
New York, NY 10036

Note To Patient: *Please bring your ID and insurance information. Note that payment will be due at time of service.*

Patient Name _____

Email _____

Phone _____ **D.O.B.** _____

CONSULTATION (choose one):

- ☐ Infertility Consult
- ☐ LGBTQ+
- ☐ Reproductive Mental Health Counseling
- ☐ Fertility Preservation
- ☐ Single Parent by Choice
- ☐ Genetic Counselor

Referring Physician _____

Physician Signature _____

Office Phone _____

All results sent via fax.

Office Fax Number _____

COMMENTS:

Know your options.

Please email this form to newpatients@springfertility.com or fax to (415) 877-1879.