Fertility Consult Referral

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

Bryant Park Clinic/Lab
114 W 41st Street
2nd Floor
New York, NY 10036

Long Island Clinic
700 Stewart Ave
Suite 200
Garden City, NY 11530

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

Referring Physician ______________________________

Physician Signature ______________________________

Office Phone ______________________________

All results sent via fax.

Office Fax Number ______________________________

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

COMMENTS:

Know your options.

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