Yale Pathology Labs
Cytopathology & Surgical Pathology

20 York Street
Yale-New Haven Hospital
New Haven, CT 06510

FINE NEEDLE ASPIRATION (FNA) & CORE BIOPSYS

For cytology reports, call (203) 785-5430
For surgical pathology reports, call (203) 785-2788 Ph: toll free 877 YALELAB Case #_____ PID# P__ __ __ __ __ __ __ __

Client (name & address):

Patient Name (Last, First, Middle Initial) _____
Maiden name:_____
Address:_____City:_____State:____ Zip:_____
Patient SS#:_____Date of Birth:_____
❒ Female ❒ Male Patient Tel. #: _____

Submitting Physician (if first submission to Yale, include UPIN number):

Also send reports to (include complete name, address, phone & fax for each):

Date Specimen Taken: _____
Time Specimen Taken: _____
Total No. of Containers: _____

❑ Self Pay ❑ Client/Doctor ❑ Insurance

Guarantor's Name:

Primary Insurance	Secondary Insurance
Insurance Name_____	Insurance Name_____
Effective Date _____	Effective Date _____
Plan Name_____	Plan Name_____
Insurance Address, City & State (Please be specific)	Insurance Address, City & State (Please be specific)
Address:_____	Address:_____
City:_____ State:_____ Zip:_____	City:_____ State:_____ Zip:_____
Insured's ID#_____	Insured's ID#_____
Insured's Name:_____	Insured's Name:_____
Group No.:_____ Payor No.:_____	Group No.:_____ Payor No.:_____
Relationship to Patient: ❑ Self ❑ Spouse ❑ Child ❑ Other	Relationship to Patient: ❑ Self ❑ Spouse ❑ Child ❑ Other
Insured's Employer:_____	Insured's Employer:_____
Insured's Address:_____	Insured's Address:_____
City/State/Zip:_____	City/State/Zip:_____

Please have all patients sign: I hereby authorize and direct my insurance carrier to pay Yale University and Yale Medical Group any benefits due under my insurance plan. I agree to pay any remaining balance, or any expenses not covered under my insurance plan. I authorize the release of any medical information necessary to process this claim. I further permit a copy of this authorization to be used in place of the original.

Patient Signature:_____

X	SPECIMEN TYPE	X	SPECIMEN TYPE
	Transthoracic, Lung		Thyroid
	Transthoracic, Mediastinum:		Breast: Right Left
	Transthoracic, Other		Lymph Node
	Liver		Intracranial, Stereotactic
	Pancreas		Intraabdominal
	Kidney		Soft Tissue
	Retroperitoneum		Salivary Gland
	Prostate		Other

HISTORY, LAB FINDINGS AND CLINICAL IMPRESSION:

SPECIFIC QUESTIONS TO BE ADDRESSED:

SPECIFIC PROCEDURES REQUESTED:

DIAGRAM OF LOCATION OF LESION

PRELIMINARY DIAGNOSIS: _____

SIGNATURE: ***M.D.***