Yale Pathology Labs

Fine Needle Aspiration (FNA) &
Core Biopsies Requisition Form

For final reports or any questions please call
Toll Free: 877 YALE LAB

789 Howard Avenue, CB 538
New Haven, CT 06519

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):

❏ Self Pay ❏ Client/Doctor ❏ Insurance

Guarantor's Name:

Primary Insurance

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

Perform Additional Genomic Testing if Indeterminate (Please check one):

❏ Perform Veracyte Affirma Thyroid FNA Analysis

❏ Perform Asuragen miR*Inform* Panel

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

Date Specimen Taken: ____________

Time Specimen Taken: ____________

Total No. of Containers: ____________

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.

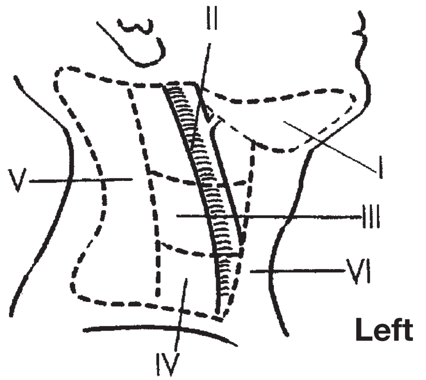
Patient Signature: ____________

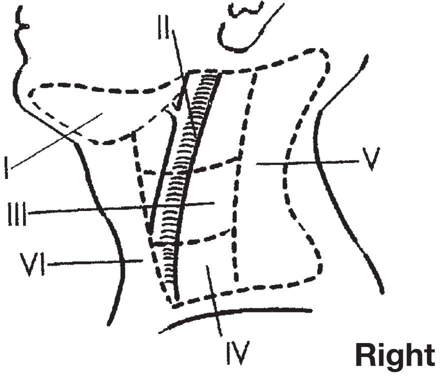
X | SPECIMEN TYPE

☐ Thyroid ☐ Lymph Node ☐ Other ____________
☐ BRAF ☐ TGB (for LN only) ☐ PTH ☐ Other ____________

DIAGRAM OF LOCATION OF LESION THYROID

DIAGRAM OF LOCATION OF LESION LYMPHNODE





HISTORY, LAB FINDINGS AND CLINICAL IMPRESSION:

SPECIFIC QUESTIONS TO BE ADDRESSED:

SPECIFIC PROCEDURES REQUESTED:

SPECIMENS SUBMITTED:

1. ____________
2. ____________
3. ____________
4. ____________
5. ____________

SIGNATURE:

M.D.