Yale Pathology Labs

Cytology & Surgical Pathology 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:____________________

Circle the ICD-9 code(s) that represent signs and/or symptoms

616.10 Vaginitis and vulvovaginitis, unspecified
616.8 Other specified inflammatory diseases of the cervix, vagina and vulva
616.9 Unspecified inflammatory disease of cervix, vagina and vulva
617.0 Endometriosis of uterus
617.9 Endometriosis, site unspecified
620.0 Follicular cyst of ovary
620.2 Other and unspecified ovarian cyst
621.2 Hypertrophy of uterus
621.8 Other specified disorders of uterus, not elsewhere classified
622.0 Erosion and ectropion of cervix
622.10 Dysplasia of cervix, unspecified
622.11 Mild dysplasia of cervix
622.12 Moderate dysplasia of cervix
622.2 Leukopiakia of cervix (uteri)
622.7 Muccous polyp of cervix
622.8 Other specified noninflammatory disorders of cervix
624.6 Polyp of labia and vulva
625.9 Pelvic Pain (female)
626.2 Excessive or frequent menstruation
626.6 Metrorrhagia
626.7 Postcoital bleeding
626.8 Other disorders of menstruation & other abnormal bleeding
626.9 Unspecified disorders of menstruation & other abnormal bleeding
627.1 Postmenopausal bleeding
627.8 Other specified menopausal and postmenopausal disorders
627.9 Unspecified menopausal and postmenopausal disorder
795.00 Abnormal glandular pap smear of cervix
795.01 Pap smear of cervix with atypical squamous cells of undetermined significance
795.02 Pap smear of cervix with atypical squamous cells cannot exclude high grade (ASC-H)
795.03 Pap smear of cervix with low grade intraepithelial lesion (LGSIL)
795.04 Pap smear of cervix with high grade squamous intraepithelial lesion (HGSIL)
795.05 Cervical high risk human papillomavirus (HPV) test positive
795.08 Unsatisfactory smear; Inadequate sample
795.09 Other abnormal pap smear of cervix and cervical HPV
ICD-9 OTHER: ____________________ **NOT STATED ABOVE**

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

Patient is here for annual screening

V76.2 Routine cervical pap screening
V 76.47 Vaginal pap smear status post-hysterectomy for non-malignant condition
V76.49 Special screening for malignant neoplasm: other sites
V15.89 Other Special personal hx presenting hazards to health

Patient is high risk

V67.01 Follow-up vaginal pap smear, status post hysterectomy for malignant condition
V10.40 Personal History of malignant neoplasm: Genital Organs
V10.41 Personal History of malignant neoplasm: Cervix uteri
V10.42 Personal History of malignant neoplasm: Other parts of uterus
V10.44 Personal History of malignant neoplasm: Other female genital organs

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:____________________

Perform HPV test: **ASCUS Only** ❑ Yes **Regardless of pap result** ❑ Yes **ASCUS LSIL** ❑ Yes
ASCUS & Above ❑ Yes **Atypical Glandular Cells** ❑ Yes **If No Endocervical Cells Present** ❑

Additional testing: (Please check all that apply)
Perform Chlamydia/Gonorrhea test ❑ Yes **Perform Affirm Bacterial Vaginosis test** ❑ Yes **Perform HPV Genotyping** ❑ Yes
Perform Cystic Fibrosis test ❑ Yes **Perform Herpes Simplex Virus I and II** ❑ Yes

History & Clinical Impression:

Specific Questions to be Answered/Procedures Requested:

Surgical Pathology

Specimens Submitted:

1
2
3
4
5

GYN Cytopathology

LMP (Required for all Paps)____________________
Check all that apply:
❑ Pregnant ❑ Postpartum ❑ On Birth Control Pills
❑ Abnormal bleeding ❑ Postmenopausal ❑ Using IUD
❑ Taking Progesterone ❑ Taking Estrogen ❑ Using Depoprovera
❑ Hysterectomy has been performed
Specimen Description (check all that apply):
❑ Endocervical ❑ Ectocervical ❑ ThinPrep
❑ Vulva ❑ Endometrial ❑ SurePath
❑ Vaginal: ❑ Pool ❑ Lateral wall ❑ Other Site____________________
❑ Other

____
Authorized Provider Signature

YSM1000 (R 11/13)