Yale Pathology Labs
Oral Pathology

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

Attn: Dr. Haberland

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:_____

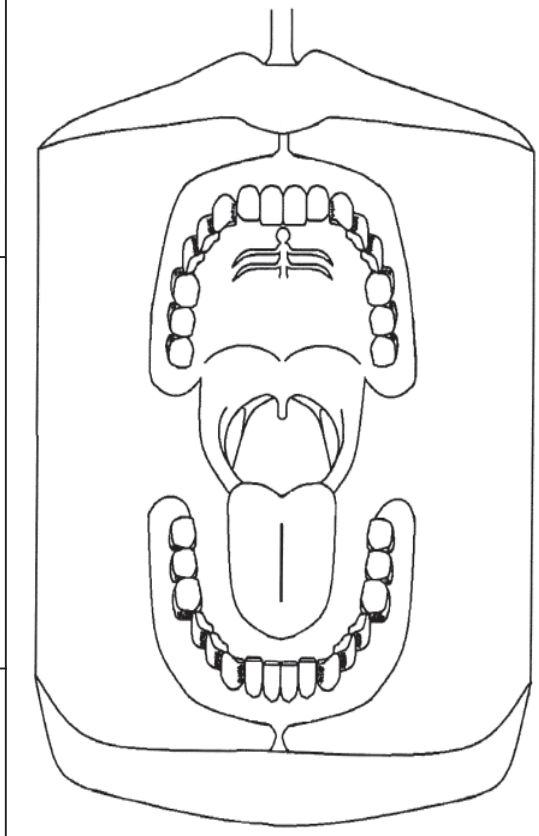
Patient SS#:_____Date of Birth:_____

❑ Female ❑ Male Patient Tel. #: _____

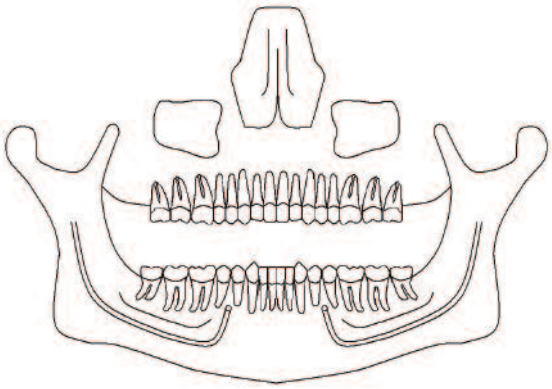
Submitting Physician (if first submission to Yale, include UPIN number):

❑ Self Pay ❑ Client/Doctor ❑ Insurance **PLEASE ATTACH INSURANCE INFORMATION**

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



PLEASE INDICATE TISSUE LOCATION



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:_____

Specimen Containers (surgical site):

Specimens Submitted:

1

2

3

Clinical Presentation (use diagram above)

Location:_____ Size:_____

Color	Shape	Texture	Consistency
___normal	___pedunculated	___smooth	___firm
___white	___sessile	___granular/rough	___fluctuant
___red	___flat	____papillary	___pulsatile
___blue	___ulcerated		
___brown/black			

___ Radiolucent	___ Unilocular	___ Expansile
___Radiopaque	___ Multilocular	___ Non-expansile
___ Mixed	___ Well defined	___ Other descriptor
	___ Ill-defined	

Clinical History / Pertinent Medical History

Clinical Diagnosis

Procedure:

____ Excisional Biopsy ____ Incisional Biopsy ____ Curretage

____ Cytology ____ Needle biopsy ____ Other (Immunoflourescence)

Previous biopsy(ies)?_____

Additional material sent? _____ Radiographs _____ Photographs

_____
Authorized Provider Signature