Yale Pathology Labs

Cytopathology & Surgical Pathology

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

THYROID

FINE NEEDLE ASPIRATION (FNA) & CORE BIOPSY

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 Guarantor's Name:

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

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:_____

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

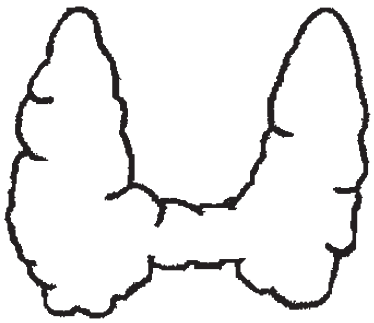
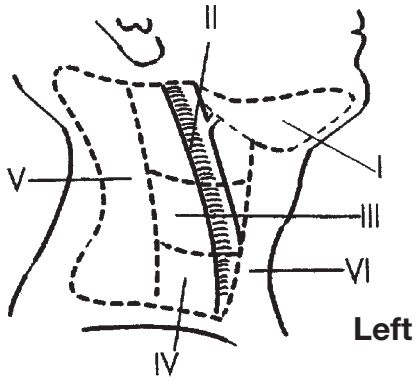
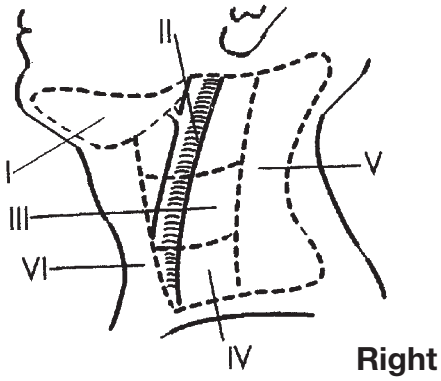


DIAGRAM OF LOCATION OF LESION LYMPHNODE





HISTORY, LAB FINDINGS AND CLINICAL IMPRESSION:

SPECIFIC QUESTIONS TO BE ADDRESSED:

SPECIFIC PROCEDURES REQUESTED:

SPECIMENS SUBMITTED:

1. _____
2. _____
3. _____
4. _____
5. _____

SIGNATURE:

M.D.