

# Yale Pathology Labs

## Cytopathology & Surgical Pathology

For cytology reports, call (203) 785-5430

For surgical pathology reports, call (203) 785-2788

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

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: _____ <input type="checkbox"/> Female <input type="checkbox"/> Male Patient Tel. #: _____
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Submitting Physician (if first submission to Yale, include UPIN number):	<input type="checkbox"/> Self Pay <input type="checkbox"/> Client/Doctor <input type="checkbox"/> Insurance Guarantor's Name: _____	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="background-color: black; color: white;">Primary Insurance</th> <th style="background-color: black; color: white;">Patient is here for annual screening</th> </tr> <tr> <td>Insurance Name _____</td> <td>V76.2 Routine cervical pap screening (excludes V72.31 Routine gyn exam)</td> </tr> <tr> <td>Effective Date _____</td> <td>V 76.47 Vaginal pap smear status post-hysterectomy for non-malignant condition</td> </tr> <tr> <td>Plan Name _____</td> <td>V76.49 Special screening for malignant neoplasm: other sites</td> </tr> <tr> <td>Insurance Address, City &amp; State (Please be specific)</td> <td>V15.89 Other Special personal hx presenting hazards to health</td> </tr> <tr> <td>Address: _____</td> <th style="background-color: black; 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Also send reports to (include complete name, address, phone & fax for each):	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="background-color: black; color: white;">Secondary Insurance</th> </tr> <tr> <td>Insurance Name _____</td> </tr> <tr> <td>Effective Date _____</td> </tr> <tr> <td>Plan Name _____</td> </tr> <tr> <td>Insurance Address, City &amp; State (Please be specific)</td> </tr> <tr> <td>Address: _____</td> </tr> <tr> <td>City: _____ State: _____ Zip: _____</td> </tr> <tr> <td>Insured's ID# _____</td> </tr> <tr> <td>Insured's Name: _____</td> </tr> <tr> <td>Group No.: _____ Payor No.: _____</td> </tr> <tr> <td>Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other</td> </tr> <tr> <td>Insured's Employer: _____</td> </tr> <tr> <td>Insured's Address: _____</td> </tr> <tr> <td>City/State/Zip: _____</td> </tr> </table>	Secondary 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: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Insured's Employer: _____	Insured's Address: _____	City/State/Zip: _____
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Insured's Employer: _____															
Insured's Address: _____															
City/State/Zip: _____															

Date Specimen Taken: _____ Time Specimen Taken: _____ Total No. of Containers: _____	Group No.: _____ Payor No.: _____ Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other Insured's Employer: _____ Insured's Address: _____ City/State/Zip: _____
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**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:** \_\_\_\_\_

History & Clinical Impression:

Specific Questions to be Answered/Procedures Requested:	Perform Chlamydia/gonorrhea test <input type="checkbox"/> yes Perform HPV test regardless of pap result <input type="checkbox"/> yes If Pap result shows ASCUS, perform HPV DNA test <input type="checkbox"/> yes Perform Affirm Bacterial Vaginosis test <input type="checkbox"/> yes
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Surgical Pathology	GYN Cytopathology	Non-GYN Cytopathology
<b>Specimens Submitted:</b> 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____	<b>LMP (Required for all Paps)</b> _____ <b>Check all that apply:</b> <input type="checkbox"/> Pregnant <input type="checkbox"/> Postpartum <input type="checkbox"/> On Birth Control Pills <input type="checkbox"/> Abnormal bleeding <input type="checkbox"/> Postmenopausal <input type="checkbox"/> Using IUD <input type="checkbox"/> Taking Progesterone <input type="checkbox"/> Taking Estrogen <input type="checkbox"/> Using Depoprovera <input type="checkbox"/> Hysterectomy has been performed <b>Specimen Description (check all that apply):</b> <input type="checkbox"/> Endocervical <input type="checkbox"/> Ectocervical <input type="checkbox"/> ThinPrep <input type="checkbox"/> Vulva <input type="checkbox"/> Endometrial <input type="checkbox"/> SurePath <input type="checkbox"/> Vaginal: <input type="checkbox"/> Pool <input type="checkbox"/> Lateral wall <input type="checkbox"/> Other Site _____ <input type="checkbox"/> Other _____	<b>Check Specimens Submitted:</b> <input type="checkbox"/> Cul-de-sac Aspiration <input type="checkbox"/> Nipple Secretion <input type="checkbox"/> Fine Needle Aspiration (Site): _____ <input type="checkbox"/> Breast Needle Aspiration <input type="checkbox"/> Other (Describe) _____ _____ _____