

FINE NEEDLE ASPIRATION (FNA) & CORE BIOPSYS

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): Submitting Physician (if first submission to Yale, include UPIN number): Also send reports to (include complete name, address, phone & fax for each): Date Specimen Taken: _____ Time Specimen Taken: _____ Total No. of Containers: _____	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. #: _____ <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;"> <thead> <tr> <th style="width:50%; text-align: center;">Primary Insurance</th> <th style="width:50%; text-align: center;">Secondary Insurance</th> </tr> </thead> <tbody> <tr> <td>Insurance Name _____</td> <td>Insurance Name _____</td> </tr> <tr> <td>Effective Date _____</td> <td>Effective Date _____</td> </tr> <tr> <td>Plan Name _____</td> <td>Plan Name _____</td> </tr> <tr> <td>Insurance Address, City & State (Please be specific) Address: _____</td> <td>Insurance Address, City & State (Please be specific) Address: _____</td> </tr> <tr> <td>City: _____ State: _____ Zip: _____</td> <td>City: _____ State: _____ Zip: _____</td> </tr> <tr> <td>Insured's ID# _____</td> <td>Insured's ID# _____</td> </tr> <tr> <td>Insured's Name: _____</td> <td>Insured's Name: _____</td> </tr> <tr> <td>Group No.: _____ Payor No.: _____</td> <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> <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> <td>Insured's Employer: _____</td> </tr> <tr> <td>Insured's Address: _____</td> <td>Insured's Address: _____</td> </tr> <tr> <td>City/State/Zip: _____</td> <td>City/State/Zip: _____</td> </tr> </tbody> </table>	Primary Insurance	Secondary Insurance	Insurance Name _____	Insurance Name _____	Effective Date _____	Effective Date _____	Plan Name _____	Plan Name _____	Insurance Address, City & State (Please be specific) Address: _____	Insurance Address, City & State (Please be specific) 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: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Insured's Employer: _____	Insured's Employer: _____	Insured's Address: _____	Insured's Address: _____	City/State/Zip: _____	City/State/Zip: _____
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Insured's Address: _____	Insured's Address: _____																										
City/State/Zip: _____	City/State/Zip: _____																										

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	X	SPECIMEN TYPE
	Transthoracic, Lung		Thyroid
	Transthoracic, Mediastinum:		Breast: Right Left
	Transthoracic, Other		Lymph Node
	Liver		Intracranial, Stereotactic
	Pancreas		Intraabdominal
	Kidney		Soft Tissue
	Retroperitoneum		Salivary Gland
	Prostate		Other

DIAGRAM OF LOCATION OF LESION

HISTORY, LAB FINDINGS AND CLINICAL IMPRESSION:

SPECIFIC QUESTIONS TO BE ADDRESSED:

SPECIFIC PROCEDURES REQUESTED:

PRELIMINARY DIAGNOSIS: _____

SIGNATURE: _____ **M.D.**