

**Yale Pathology Labs**  
**Gastrointestinal and Liver Pathology**  
**Outreach Service**

20 York Street  
 Yale-New Haven Hospital  
 New Haven, CT 06510  
 Ph: toll free 877 YALELAB  
 or Ph: 203-785-2788

Case # \_\_\_\_\_ PID# P \_\_\_\_\_

Client (name & address):   Submitting Physician (if first submission to Yale, include UPIN number):  Physician's UPIN: Total No. of Containers: _____ Date Specimen Taken: _____ Time Specimen Taken: _____	Patient Name (Last, First, Middle Initial) _____ Maiden name: _____ Address: _____ City: _____ State: _____ Zip: _____  Self Pay    Client/Doctor    Insurance    Guarantor's Name: _____ <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width:50%;">Primary Insurance</th> <th style="width:50%;">Secondary Insurance</th> </tr> <tr> <td>Insurance Name _____</td> <td>Insurance Name _____</td> </tr> <tr> <td>Plan Name _____</td> <td>Plan Name _____</td> </tr> <tr> <td>Insurance Address, City &amp; State (Please be specific) Address: _____</td> <td>Insurance Address, City &amp; 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:    Self    Spouse    Child    Other</td> <td>Relationship to Patient:    Self    Spouse    Child    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> </table>	Primary Insurance	Secondary Insurance	Insurance Name _____	Insurance Name _____	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:    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: _____	Patient SS#: _____ Date of Birth: _____ Female    Male Patient Tel. #: _____
Primary Insurance	Secondary Insurance																									
Insurance Name _____	Insurance Name _____																									
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:    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: _____																									

History (including prior procedures):          Medications: _____	Clinical Impression:          Procedure and Bowel Prep Used: _____
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Endoscopic Photo Included    Endoscopic Report Included    Endoscopic or Operative Findings or Assessment:
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Specimens Submitted	
*Bx#	CM.
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