Yale Dermatopathology

A PRACTICE OF THE YALE MEDICAL GROUP

Phone (203) 785-4094 Fax (203) 785-6869

LAB USE ONLY

Date of Biopsy:________________________

Submitting Physician:____

Fax additional copy to:________________________ PH#_________________ FX# ________________________

Name, Last___________________________First ___________________________Birth date________________

Address____

City____State______________Zip__________________

Telephone # (   )____________________ M [ ] F [ ] Social Security #_________ -______-___________

***MANDATORY**: Attach a copy of the patient's insurance card. If none, please complete below.*

Insurance Company (and **PLAN NAME**):____

Insured's ID #__________________________________Group Number # _______________________________

Policy Holder's Name____

Patient's Relationship to Insured: Self____ Spouse____ Child____ Other____

PARTIAL BIOPSY? **Please √ if: Folliculitis ❑ Alopecia ❑**

BIOPSY SITE	YES	NO	CLINICAL DESCRIPTION	CLINICAL DDX
A.				
B.				
C.				
D.				
E.				

Gross: **Previous Bx#:**________________________

- ❑ **Not in YDP Formalin**
- ❑ **Bottle Leaking**
- ❑ **No Site/Name/MD on Bottle**
- ❑ **Multiple Specimens in Bottle**
- ❑ **No Tissue Identified**
- ❑ **Contents Strained**

Information on this form may be included in Yale-New Haven Hospital (YNHH)'s medical record information repository. Please sign below if you do not want this protected health information to be housed in YNHH's secure medical record program.

PATIENT SIGNATURE:____