

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

Date of Biopsy: _____

Submitting Physician _____

Resident's Name _____

Fax additional copy to: _____

PH# _____ FX# _____

| | | |
|---|------------------|-----------------|
| Last Name _____ | First Name _____ | Birthdate _____ |
| Address _____ | | |
| City _____ | State _____ | Zip _____ |
| Telephone # () _____ M [] F [] Social Security # _____ - _____ - _____ | | |

Previous Bx#: _____

PARTIAL BIOPSY?

Please ✓ if: Folliculitis Alopecia

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

Gross:

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.

- Not in YDP Formalin
- Bottle Leaking
- No Site/Name/MD on Bottle
- Multiple Specimens in bottle
- No Tissue Identified

PATIENT SIGNATURE: _____