Yellowstone Pathology Institute
interactive diagnostics

2900 12th Avenue North, Suite 295W
Billings, MT 59101
Phone: (406) 238-6360 • (888) 400-6640
Fax: (406) 238-6361

(307) 578-1850
707 Sheridan Avenue
Cody, WY 82414

Scott M. Bibbey, MD, FCAP
Michael S. Brown, MD, FCAP
Angela F. Durden, MD, FCAP
Kerrie R. Emerick, MD, FCAP
Nick Luem, MD, FCAP
Christopher J. Nero, MD, FCAP
Christopher L. Rozelle, MD, FCAP
Kelli M. Schneider, MD, FCAP

ADDITIONAL REPORT TO: (No copy will be sent without full name & address)

YPI Accession #:

PATIENT INFORMATION

Patient's Name: (Last) (First) (MI)

Date of Birth: / / Sex: SSN: Phone: Chart #:

Patient's Address: City: ST: Zip:

BILLING INFORMATION

Insurance: Hospital ❑IP ❑OP ❑ Private Practice ❑ Hospital Owned Practice ❑ Insurance ❑ Uninsured ❑ Medicare ❑ Work Comp DOI:__/__/__

SEPARATE SHEET SHOWING PATIENT DEMOGRAPHIC INFORMATION MUST BE ATTACHED

Primary Insurance Name: ______________________
Ins ID #: ______________ Ins Group #: ______________
Policy Holder Name: ______________ DOB: __________
Address: ______________ Phone: __________
City: ______________ State: ____ Zip: __________

Secondary Insurance Name: ______________________
Ins ID #: ______________ Ins Group #: ______________
Policy Holder Name: ______________ DOB: __________
Address: ______________ Phone: __________
City: ______________ State: ____ Zip: __________

CLINICAL DATA

Date of Service ____/____/____ Collection Time___:___am pm Ordering Physician ______________

Clinical History: ______________________

Clinical Diagnosis: ______________________

Reason for Today's Visit: ICD-10 code(s) (REQUIRED) ______________________

SURGICAL SPECIMENS • *Please label slides/specimen container with Patient Name & Date of Birth*

For Breast Tissue: Collection Time ___:___ am pm
Time into fixative (must be 10% Neutral Buffered Formalin): _____:_____ am pm

Specimen #	Specimen Description	Anatomic Location	Procedure
1			
2			
3			
4			
5			
6			

FLOW CYTOMETRY • *Please include most recent CBC report*

❑ Fetal Hemoglobin
❑ Leukemia/Lymphoma Phenotyping
❑ Bone Marrow ❑ Peripheral Blood ❑ Other ______________
❑ Platelet Antibodies (For Thrombocytopenia Profile, see below)
❑ PNH
❑ Reticulated Platelet
❑ Stem Cell Enumeration
❑ Thrombocytopenia Profile (Platelet Antibody & Reticulated Platelet)
❑ ZAP-70

❑ **REFER SPECIMEN FOR CYTOGENETICS**

❑ **HOLD FOR FLOW CYTOMETRY**

MOLECULAR TESTING

❑ BRAF* ❑ EGFR*
❑ HER-2 Gene Amplification (D-ISH)*
❑ JAK2 V617F Mutation*
❑ KRAS*
❑ OTHER* ______________

IHC TESTING
❑ **ER/PR** (mark one below)
❑ Pre-menopausal
❑ Post-menopausal

❑ Cystic Fibrosis Screen* Reproductive Partner CF Carrier? ❑Yes ❑No
Patient Family Hx of CF? ❑ Yes Relationship: ______________ ❑ No
Ethnicity: ❑ Cauc ❑ Am Ind ❑ Hisp ❑ Afr Am ❑ Asian ❑ Other

PHYSICIAN / PROVIDER INFORMATION

ICD-10 diagnosis code(s) must be provided for each test ordered. Only tests that you believe are appropriate for patient care should be ordered. Medicare will only pay for tests that are medically necessary for the diagnosis and treatment of the patient rather than for screening purposes.

The advanced beneficiary notice must give the patient (beneficiary) an idea of why the physician / provider is predicting the likelihood of Medicare denial so the patient (beneficiary) can make an informed decision whether or not to receive the service and pay for it out-of-pocket.

DEFINITION OF “HIGH RISK” PATIENT:

A. The patient is of childbearing age and has had an examination that indicated the presence of cervical or vaginal cancer or some abnormality during any of the preceding three years; or
B. Regardless of the patient’s age, she is considered to be at high risk of developing cervical or vaginal cancer due to at least one of the following factors:
    1. early onset (under 16 years of age) of sexual activity;
    2. multiple sexual partners (five or more to date);
    3. history of sexually transmitted disease (including HIV infection);
    4. fewer than three negative PAP smears within the previous seven years; or
    5. mother took DES (diethylstilbestrol) during pregnancy with patient.

DEFINITION OF “DIAGNOSTIC” PAP SMEAR

A “diagnostic PAP smear” is one that is ordered by the referring physician using that distinction based on his/her finding that one or more of the following circumstances applies to the Medicare beneficiary at hand.

1. The patient has been previously diagnosed with cancer of the vagina, cervix, or uterus that has been or is presently being treated;
2. The patient has had a previous abnormal PAP smear;
3. The patient presents any current abnormal findings of the vagina, cervix, uterus, ovaries, or adnexa;
4. The patient presents any significant complaint referable to the female reproductive system; or
5. The patient shows any sign or symptom that might, in the referring physician’s judgement, reasonably be related to a gynecologic disorder.