Yellowstone Pathology Institute
interactive diagnostics

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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: _____ Secondary Insurance Name: _____

Ins ID #: _____ Ins Group #: _____ Ins ID #: _____ Ins Group #: _____

Policy Holder Name: _____ DOB: _____ Policy Holder Name: _____ DOB: _____

Address: _____ Phone: _____ Address: _____ Phone: _____

City: _____ State: ___ Zip: _____ 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* _____

❑ 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

IHC TESTING

❑ **ER/PR** (mark one below)

❑ Pre-menopausal

❑ Post-menopausal

WHITE COPY - YPI CANARY COPY - CLIENT / SURGERY *PATHOLOGIST INTERPRETATION PERFORMED UNLESS OTHERWISE SPECIFIED

FORM #010 REV. 4/20

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.