



F40-D Emergency Preparedness Specimen Submission Form (SEP 2015)
 CLIA #45D0503753 CAP #2148801
 Laboratory Services Section
 South Texas Laboratory
 1301 S. Rangerville Road
 Harlingen, Texas 78552
 (956) 364-8746
 FAX: (956) 412-8794

Place DSHS Bar Code Label / Addressograph Here

Section 1. SUBMITTER INFORMATION -- (REQUIRED)**

Submitter/TPI Number ** Submitter Name **

NPI Number ** Address **

City ** State ** Zip Code **

Phone ** Contact

Fax ** Clinic Code

Section 2. PATIENT INFORMATION -- (REQUIRED)**

NOTE: Patient name is REQUIRED & MUST match name on this form, Medicare/Medicaid card, & specimen container

Last Name ** First Name ** MI

Address ** Telephone Number

City ** State ** Zip Code ** Country of Origin / Bi-National ID #

DOB (mm/dd/yyyy) ** Sex ** SSN Pregnant?
 Yes No Unknown

Race: White Black or African American Hispanic
 American Indian / Native Alaskan Asian Non-Hispanic
 Native Hawaiian / Pacific Islander Other Unknown

Section 3. SPECIMEN SOURCE OR TYPE -- (REQUIRED)**

Abscess (site) _____ Gastric Sputum: Natural
 Blood Lesion (site) _____ Throat swab
 Bone marrow Lymph node (site) _____ Tissue (site) _____
 Bronchial washings Nasopharyngeal Wound (site) _____
 CSF Rectal swab Other:
 Eye Serum
 Feces/stool Sputum: Induced

Section 5. ORDERING PHYSICIAN INFORMATION -- (REQUIRED)**

Ordering Physician's NPI Number ** Ordering Physician's Name **

Section 6. PAYOR SOURCE -- (REQUIRED)

1. Reflex testing will be performed when necessary and the appropriate party will be billed.
 2. If the patient does not meet program eligibility requirements for the test requested and no third party payor will cover the testing, the submitter will be billed.
 3. Medicare generally does not pay for screening tests-please refer to applicable Third party payer guidelines for instructions regarding covered tests, benefit limitations, medical necessity determinations and Advanced Beneficiary Notice (ABN) requirements.
 4. If Medicaid or Medicare is indicated, the Medicaid/Medicare number is required. Please write it in the space provided below.
 5. If private insurance is indicated, the required billing information below is designated with an asterisk (*).
 6. Check only one box below to indicate whether we should bill the submitter, Medicaid, Medicare, private insurance, or DSHS Program.

Medicaid (2) Medicare (8)

Medicaid/Medicare #: _____

Submitter (3) Private Insurance (4)

BIDS (1720) Other: _____
 BT Grant (1719)
 IDEAS (1610)
 Zoonosis (1620)

Date of Collection ** (REQUIRED) Time of Collection AM PM Collected By

HMO / Managed Care / Insurance Company Name *

Medical Record # Alien # / CUI / CDC ID Previous DSHS Specimen Lab Number

Address *

ICD Diagnosis Code ** (1) ICD Diagnosis Code ** (2) ICD Diagnosis Code ** (3)

City * State * Zip Code *

Date of Onset Diagnosis / Symptoms Risk

Responsible Party *

Inpatient Outpatient Outbreak association: Surveillance

Insurance Phone Number * Responsible Party's Insurance ID Number *

Group Name Group Number

"I hereby authorize the release of information related to the services described here and hereby assign any benefits to which I am entitled to the Texas Department of State Health Services, Laboratory Services Section."
Signature of patient or responsible party.

Signature * Date *

Section 4. BACTERIOLOGY

NOTES: For rule-out testing. Please notify lab prior to sending samples to expedite testing at (956) 364-8369.

Clinical specimen:
 Aerobic Culture
 Organism suspected: _____

Definitive Identification:
 Bacillus anthracis
 Brucella spp.
 Burkholderia mallei/pseudomallei
 Francisella tularensis
 Yersinia pestis

NOTES: For pure culture ID and typing, please provide biochemical reactions on reverse side of form or attach copy of biochemistry printout. Each test block (ex. Bacteriology) requires a separate form and specimen. Please see the form's instructions for details on how to complete this form. Visit our web site at <http://www.dshs.state.tx.us/lab/>.
 @ = Provide patient history on reverse side of form to avoid delay of specimen processing.
 NOTE: All dates must be entered in mm/dd/yyyy format.

FOR LABORATORY USE ONLY Specimen Received: Room Temp. Cold Frozen