TEXAS Health and Human Services | Texas Department of State Health Services

(956) 364-8746 FAX: (956) 412-8794

F40-D Emergency Preparedness Specimen Submission Form (Jan 2020)

CLIA #45D0503753 CAP #2148801

www.dshs.texas.gov/lab/so_tx_lab

Place DSHS Bar Code Label / Address-O-Graph 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 ☐ American Indian / Native Alaskan ☐ Asian ☐ Native Hawaiian / Pacific Islander ☐ Other

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Date of Collection ** **REQUIRED)**	Time of Collection ☐ AM ☐ PM	Collected By
Medical Record #	Alien # / CUI / CDC ID	Previous DSHS Specimen Lab Number
ICD Diagnosis Code ** (1)	ICD Diagnosis Code ** (2)	ICD Diagnosis Code ** (3)
Date of Onset	Diagnosis / Symptoms	Risk

☐ Inpatient ☐ Outpatient ☐ Outbreak association: ☐ Surveillance

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

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

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 (1710)

☐ Zoonosis (1620)

HMO / Managed Care / Insurance Company Name *		
Address *		
City *	State *	Zip Code *
Responsible Party *		
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 for 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/.
NOTE: All dates must be entered in mm/dd/yyyy format.

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