TEXAS Department of State Health Services

Specimen Acquisition: (512) 776-7598

G-THSTEPS (Sept 2017)
Specimen Submission Form
CAP# 3024401 CLIA #45D0660644
Laboratory Services Section, MC-1947
P. O. Box 149347, Austin, Texas 78714-9347
Courier: 1100 W. 49th Street, Austin, Texas 78756
(888) 963-7111 x7318 or (512) 776-7318
http://www.dshs.texas.gov/lab

****For DSHS Use Only****
Place DSHS Bar Code Label Here

FOR TEXAS HEALTH STEPS SPECIMENS ONLY !!!

IS THIS LABORATORY SUBMISSION PART OF THE THSTEPS MEDICAL CHECKUP OR FOLLOW-UP VISIT? ☐ Yes ☐ No

The specimen submission form ***must*** accompany ***each*** specimen.
The patient's name listed on the specimen ***must*** match the patient's name listed on the form.
Specimen must have two (2) identifiers that match this form.
If the Date of Collection field is not completed, the specimen will be rejected.

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** on specimen is **REQUIRED & MUST** match name on this form & Medicaid card.
Specimen must have two (2) identifiers that match this form.

Last Name **	First Name **	MI
Address **	Telephone Number	
City **	State ** / Zip Code ** / Country of Origin	
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 Number	Alien # / CUI / CDC ID	Previous DSHS Specimen Lab Number
ICD Diagnosis Code ** (1)	ICD Diagnosis Code ** (2)	ICD Diagnosis Code ** (3)

Section 3. SPECIMEN TYPE

☐ Blood: Capillary	☐ Plasma	☐ Urine
☐ Blood: Venous	☐ Serum	☐ Vaginal
☐ Endocervical	☐ Urethral	☐ Other:

NOTES: All dates must be entered in mm/dd/yyyy format.
Please see the form's instructions for details on how to complete this form.
Details of test and specimen requirements can be found in the Laboratory Testing Services Manual.
Visit our web site at http://www.dshs.texas.gov/lab/.

▲ = If stored in an appliance prior to shipping, document **date & time** specimens were **removed from FREEZER / REFRIGERATOR** in the lower right-hand box.

⇮ = Package specimen to ensure that the shipping temperature of 2°C-30°C (36°F-86°F) is maintained.

Section 4. ORDERING PHYSICIAN INFORMATION -- (** REQUIRED)

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

Section 5. 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. If the Medicaid number is not provided or is inaccurate, the submitter will be billed.
4. Please write the Medicaid number in the space provided below.

☒ **THSteps** (1)

Medicaid #: **_____

Section 6. HL

☐ **Hemoglobin**

☐ **Lead**

If this is a follow-up due to a previous abnormal or elevated result, mark "Yes" below and provide previous DSHS specimen lab number in Section 2.

☐ Yes

Section 7. STD

☐ **Gonorrhea/Chlamydia (GC/CT), Amplified RNA probe** ⇮
☐ **HIV** ▲
☐ **Syphilis** ▲

***NOTE:* *DO NOT* freeze *S*erum *S*eparator *T*ube (SST) collectors (i.e. Gold Top tubes)**

Section 8. CHEMISTRIES

☐ **Cholesterol** ▲
☐ **High-density lipoprotein (HDL)** ▲
☐ **Lipid panel** ▲
(Includes cholesterol, triglycerides, HDL, and low-density lipoprotein (LDL))
☐ **Glucose, Random** {Diabetes} ▲
☐ **Glucose, Fasting** {Diabetes} ▲

***NOTE:* *DO NOT FREEZE S*erum *S*eparator *T*ube (SST) collectors (i.e. Gold Top tubes)**

▲ REQUIRED for cold shipments, if stored in an appliance prior to shipping. Indicate REMOVAL from:

☐ **FREEZER** ☐ **REFRIGERATOR**

DATE (mm/dd/yyyy)	**TIME** (hr min) ☐ AM ☐ PM

FOR LABORATORY USE ONLY

Comments:

Specimen Received: ☐ Room Temp. ☐ Cold ☐ Frozen

For assistance or questions, email ClinicalChemistry@dshs.texas.gov.

Biochemistry and Genetics

G-THSTEPS Specimen Submission Form Instructions

For mailing and specimen packaging information, visit DSHS Laboratory Services Section's web page at http://www.dshs.texas.gov/lab/.

The specimen submission form ***must*** accompany ***each*** specimen.
The patient's name listed on the specimen ***must*** match the patient's name listed on the form.
Specimen must have two (2) identifiers that match the form.
If the Date of Collection field is not completed or is inaccurate, the specimen will be rejected.

Place DSHS Bar Code Label Here: Leave this space blank. It is for DSHS Lab Staff Use ONLY.

Section 1. SUBMITTER INFORMATION

All submitter information that is required is marked with double asterisks (**).

Submitter/TPI Number, Submitter Name and Address: The submitter number is a unique number that the Texas Department of State Health Services (DSHS) Laboratory Services Section assigns to each of our submitters. For Texas Health Steps (THSteps) specimens, use the pre-assigned Texas Provider Identifier (TPI) number. To obtain a TPI number and THSteps enrollment, contact Texas Medicaid and Healthcare Partnership (TMHP) at 1-800-925-9126.

To request a DSHS Laboratory Services Section submitter number, a master form, or to update submitter information, please call (888) 963-7111 x7578 or (512) 776-7578, or fax (512) 776-7533, or visit http://www.dshs.texas.gov/lab/mrs_forms.shtm#email.

NPI Number: Indicate the facility's 10-digit National Provider Identifier (NPI) number. All health care providers must use the National Provider Identifier (NPI) number. To obtain an NPI number, contact the National Plan and Provider Enumeration System (NPPES) toll free at (800) 465-3203 or via their web site at https://nppes.cms.hhs.gov/NPPES/Welcome.do.

Indicate the submitter's name, address, city, state, and zip code. Please print clearly, use a pre-printed label, or use a legible photocopy of a master form provided by the Laboratory Services Section. **Do not use any specimen submission forms with "SAMPLE" watermarked on it**. For updates or changes to submitter information, please contact Lab Reporting at (512) 776-7578.

Contact Information: Indicate the name, telephone number, and fax number of the person to contact at the submitting facility in case the laboratory needs additional information about the specimen.

Clinic Code: Provide, if applicable. This is a code that the submitter furnishes to help them identify which satellite office submits a specimen and to help the submitter identify where the lab report belongs, if the submitter has a primary mailing address with satellite offices.

Section 2. PATIENT INFORMATION

Complete all patient information including last name, first name, middle initial, address, city, state, zip code, telephone number, country of origin, race, ethnicity, date of birth (DOB), sex, social security number (SSN), pregnant, date of collection, time of collection, medical record number, ICD diagnosis code, and previous DSHS specimen lab number.

NOTE: The patient's name listed on the specimen ***must*** match the patient's name listed on the specimen submission form.

All specimens must be labeled with at least two patient specific identifiers; both a primary and a secondary identifier. The identifiers must appear on both the primary specimen container (or card) and the associated submission form. Specimens that do not meet this criteria **will be considered unsatisfactory** for testing.

Acceptable identifiers are listed below:

List of Acceptable Identifiers (2 identifiers are required to make a positive ID)	**Identifier Type** (Patient Name + at least 1 secondary ID)
Patient Name (last name, first name)	Primary **(required)**
Date of Birth	Secondary **(preferred)**
Medical Record Number	Secondary
Social Security Number	Secondary
Medicaid Number	Secondary
Newborn Screening Kit Number	Secondary
CDC Number	Secondary

Information that is required to bill Medicaid has been marked with double asterisks (**). These fields must be completed. You may use a pre-printed patient label.

Patient Name: The name on the specimen submission form and specimen must match the name on the Medicaid card.

Date of birth (DOB): List the date of birth. If date of birth is not provided or is inaccurate, specimen may be rejected.

Pregnant: Indicate if female patient is pregnant by marking either Yes, No, or Unknown.

Date of Collection/Time of Collection: Indicate the date and time the specimen was collected from the patient. Do not give the date the specimen was sent to DSHS. **IMPORTANT: If the Date of Collection field is not completed or is inaccurate, the specimen will be rejected.**

Collected By: Clearly indicate the individual who collected the specimen.

Medical Record Number: Provide the identification number for matching purposes.

Alien# / CUI / CDC ID: Provide the Alien number. CUI is the Clinic Unique Identifier number. CDC ID, if applicable

Previous DSHS Specimen Lab Number: If this patient has had a previous specimen submitted to the DSHS Laboratory, please provide the DSHS specimen lab number.

ICD Diagnosis Code(s): Indicate the diagnosis code that would help in processing, identifying, and billing of this specimen.

Section 3. SPECIMEN TYPE

Specimen Type: Indicate the type of specimen that is being submitted.

Section 4. PHYSICIAN INFORMATION

Ordering Physician's NPI Number and Name: Give the physician's NPI number and physician's name. **This information is required to bill THSteps.**

Section 5. PAYOR SOURCE

THE SUBMITTER WILL BE BILLED, if the required billing information is not provided or is inaccurate.

- Write in the Medicaid number.
- If the patient name on the form does not match the name on the Medicaid card, the submitter will be billed.
- NOTE: The DSHS laboratories are not an in-network CHIP or CHIP Perinate provider. If CHIP or CHIP Perinate is indicated, the submitter will be billed

Section 6. HL

Test Requested: Mark the specific test(s) to be performed by the Laboratory Services Section. To cancel a test that is marked in error on the specimen submission form, mark one line through the test name, write "error", and initial.

Section 7. STD

Test Requested: Mark the specific test(s) to be performed by the Laboratory Services Section. To cancel a test that is marked in error on the specimen submission form, mark one line through the test name, write "error", and initial.

Gonorrhea/Chlamydia (GC/CT) Amplified RNA probe: Testing for gonorrhea and chlamydia (GC/CT). Package specimen to ensure that the shipping temperature of 2°C-30°C (36°F-86°F) is maintained.

HIV & Syphilis RPR: Serum specimens must be frozen or refrigerated, according to the test requested. DO NOT FREEZE serum separator tubes. Provide the date and time and mark the appropriate appliance, REFRIGERATOR or FREEZER, from which the specimen(s) were removed.

Syphilis RPR: Reflex testing (RPR titer, RPR confirmatory) will be performed on positive RPR screens.

REFLEX & REFERENCE TESTING:

Additional testing procedures (i.e., reflex testing) will be performed when necessary and clinically indicated by the initial lab test results. Reflex testing will be billed to the appropriate payor in addition to the original test requested.

This is particularly applicable to microbiology testing and other laboratory testing requiring confirmation or further diagnostic work.

All reference tests will be billed to the submitter at the prevailing reference laboratory's price with the addition of a handling fee.

Section 8. CHEMISTRIES

Test Requested: Mark the specific test(s) to be performed by the Laboratory Services Section. To cancel a test that is marked in error on the specimen submission form, mark one line through the test name, write "error", and initial.

Lipid Panel, Cholesterol, HDL, and Glucose: Serum specimens must be frozen or refrigerated, DO NOT FREEZE serum separator tubes. Provide the date and time and mark the appropriate appliance. FREEZER or REFRIGERATOR, from which the specimen(s) were removed.

For specific test instructions and information about tube types, see the Laboratory Services Section's Laboratory Testing Services Manual on our web site at **http://www.dshs.texas.gov/lab/**.