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

South Texas Laboratory
CAP #2148801 CLIA #45D0503753
Phone: (956) 364-8746 **Fax:** (956) 412-8794

SPECIMEN BARCODE / Address-O-Graph

This Space for DSHS Laboratory Use Only

F40-A Specimen Submission Form

SECTION 1. SUBMITTER

** REQUIRED

Submitter/TPI Number **	Submitter Name**	
NPI Number **	Address **	
City **	State **	Zip Code **
Phone Number **	Fax **	Contact Name and/or Email Address

SECTION 2. PATIENT

NOTE: **Patient name** on specimen MUST match name on this form **exactly**.
Name mismatches will be rejected. *e.g., Partial name on specimen label but full name is provided on form.*
Specimen **container must have two (2) unique identifiers** that match this form exactly. *e.g.,Name. DOB.*

** REQUIRED

Last Name **	First Name **	MI
Address **		Phone Number
City **	State **	Zip Code **
DOB *(mm/dd/yyyy)* **	Sex**	Pregnant? ☐ Yes ☐ No ☐ Unknown

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Race: ☐ White ☐ American Indian / Native Alaskan ☐ Asian ☐ Black or African American ☐ Native Hawaiian / Pacific Islander ☐ Other

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

† Indicate the diagnosis code that would help in processing identifying, billing this specimen.

SECTION 3. SPECIMEN

NOTE: If the 'Date of Collection' field is not completed, the specimen will be rejected.

** REQUIRED

Date of Collection *(mm/dd/yyyy)* **	Time of Collection ** ☐ AM ☐ PM	Collected by:

Specimen Source or Type

☐ Blood ☐ Urine
☐ Serum

SECTION 4. ORDERING PHYSICIAN

**** REQUIRED**

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

SECTION 5. PAYOR SOURCE

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 will cover the testing, **the submitter will be billed.**
3. Medicare generally does not pay for screening tests-please refer to applicable Third-party payor 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.
5. **Check only one box below** to indicate whether we should bill the submitter, Medicaid, Medicare, or DSHS Program.

** REQUIRED

☐ Submitter (3)
☐ Pub Hlth Follow Up (1608)
☐ HIV Prevention (1611)
☐ OPC (5507)
☐ Private Insurance
☐ Other: _____
☐ Medicaid (2)
☐ Medicare (8)
Medicaid/Medicare #: _____

HMO / Managed Care / Insurance Company Name *

Address:

City *	State *	Zip *

Responsible Party/Subscriber *

Insurance Phone Number *	Insurance ID Number *
Group Name	**Group Number**

Signature of Patient or Responsible Party
***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, Public Health Laboratory Division

Signature *	Date *

Section 6. CHEM PANELS

☐ Basic Metabolic Panel ♥
☐ Comp Metabolic Panel ♥
☐ Electrolytes Panel
☐ Hepatic Function Panel
☐ Lipid Profile Panel ♥
☐ Renal Function Panel
☐ **TB Panel: (ALT); (AST); (Alk Phos); (** Billi, T); (BU (Chol); (Creat); (GGT); (Uric Acid)

Section 7. CHEMISTRY

☐ Albumin
☐ Alkaline Phosphatase
☐ ALT (SGPT)
☐ Amylase
☐ AST (SGOT)
☐ Bilirubin, Direct
☐ Bilirubin, Total
☐ Bilirubin, total & direct profile
☐ Blood Urea Nitrogen (BUN)
☐ Calcium
☐ Carbon dioxide (CO2)
☐ Chloride
☐ Cholesterol, Total
☐ Cholesterol HDL
☐ Cholesterol LDL
☐ Creatine kinase (CK)
☐ Creatinine
☐ GGT
☐ Glucose
☐ Glucose 2 Hr PP
☐ Hemoglobin A1C
☐ Iron, Total
☐ Iron Binding Capacity, Total (TIBC)
☐ Lactic Acid Dehydrogenase (LDH)
☐ Lipase
☐ Magnesium
☐ Phosphorus
☐ Potassium
☐ Protein, Total
☐ Sodium
☐ Triglycerides
☐ Uric Acid

Section 8. HEMATOLOGY

☐ CBC automated w/differential *
☐ Differential, Manual
☐ Hematocrit
☐ Hemoglobin, Total
☐ Peripheral Smear Review

Section 9. URINALYSIS

☐ Urine Micro Albumin Random
☐ Urinalysis *
☐ Microscopy with Urinalysis (UA)

Section 10. SPECIAL CHEMISTRY

☐ Ferritin
☐ FSH
☐ LH
☐ Prolactin
☐ PSA, Total
☐ Thyroid Stimulating Hormone (TSH)
☐ Thyroxine (T4), Free
☐ Thyroxine (T4), Total
☐ Thyroid Hormone (T3) Uptake
☐ Tri-iodothyronine (T3), free

NOTES:
♥ = Fasting preferred for test.
▲= Document **time & date** specimens were **removed from REEZER/REFRIGERATOR** in the lower right-hand box

*Additional testing procedures will be ordered as reflex testing if clinically indicated.

▲ **REQUIRED for Section 7 – If specimen is stored in an appliance prior to shipping, Indicate REMOVAL from:**
☐ FREEZER ☐ REFRIGERATOR

DATE (mm/dd/yyyy)	TIME (hh:mm) ☐ AM ☐ PM