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

Remember 1-1

1 FORM = 1 SAMPLE
Please complete a separate form for each specimen submitted

SPECIMEN BARCODE / Address-O-Graph
This Space for DSHS Laboratory Use Only

F40-D 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., DOB, Unique ID#.*

** REQUIRED

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

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

Diagnosis / Symptoms Θ	Risk	☐ Inpatient ☐ Outpatient
Date of Onset Θ	☐ Outbreak Association Θ ☐ Surveillance Θ	Country of Origin / Bi-National ID Θ
ICD Diagnosis Code † (1)	ICD Diagnosis Code † (2)	ICD Diagnosis Code † (3)

Θ Indicates fields of epidemiological interest. If sample/test is related to an epidemiology investigation complete relevant fields.

† Indicate the diagnosis code that would help in processing, identifying, and billing of 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:
Unique Identification Number ** *e.g., MRN / Alien # / Accession ID*	Comments or Additional ID: *e.g., CDC ID, Previous DSHS Specimen Lab Number*	

Specimen Source or Type (Select One Only) **

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

SECTION 4. BACTERIOLOGY RULE-OUT

NOTES: For rule-out testing, Please notify lab prior to sending samples for expedite testing at [illegible]69.

Clinical specimen:
☐ Aerobic [illegible]
Organism suspected _____

Presumptive Identification
☐ Bacillus anthracis
☐ Brucella spp.
☐ Burkholderia mallei/pseudomallei
☐ Francisella tularensis
☐ Yersinia pestis

Section 7. MOLECULAR

☐ Multiplex test
Justification: ☐ Surveillance ☐ Outbreak ☐ Other _____

☐ Zika, Dengue, and/or Chikungunya

NOTE: PCR will be performed at DSHS-STL and the testing methodology and specific viruses approved for testing will be based on clinical symptoms and epidemiological criteria.

In some instances, specimens may be forwarded to DSHS-Austin and/or CDC for further testing.

FOR DSHS USE ONLY
Testing Criteria? ☐ Met ☐ Not Met

PCR	Serology	Initials	Date
☐ C	☐ C		
☐ D	☐ D		
☐ Z	☐ Z		

SECTION 5. ORDERING PHYSICIAN

** REQUIRED

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

SECTION 6. PAYOR SOURCE

1. **Reflex testing** will be performed when necessary [illegible] 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 [illegible] for 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)	☐ OPC (5507)
☐ BIDS (1720)	☐ TB Elimination (1619)
☐ BT Grant (1719)	☐ Other:
☐ IDEAS (1610)	_____
☐ Zoonosis (1620)	
☐ Medicaid (2)	☐ Medicare (8)
Medicaid/Medicare #: _____	

Notes/Comments:

NOTES: 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 www.dshs.state.tx.us/lab/. NOTE: All dates must be entered in mm/dd/yyyy format.

▲ **REQUIRED for cold/frozen shipments, if stored in an appliance. Indicate removal from:**

FOR LABORATORY USE ONLY | Specimen Received: ☐ Room Temp ☐ Cold ☐ Frozen | ☐FREEZER ☐ FRIDGE | DATE: TIME: