



This Space for DSHS Laboratory Use Only

F40-TB Elimination Specimen Submission Form- South Texas Laboratory

SECTION 1. SUBMITTER INFORMATION (\*\* REQUIRED)
SECTION 3. ORDERING PHYSICIAN
\*\* REQUIRED
Physician's NPI Number\*\* Physician's Name\*\*

SECTION 2. PATIENT
NOTE: Patient name on specimen MUST match name on this form exactly.
Name mismatches will be rejected.
Specimen container must have two (2) unique identifiers that match this form exactly.
Last Name \*\* First Name \*\* MI
Address \*\* Phone Number
City \*\* State \*\* Zip Code \*\* Pregnant?
DOB (mm/dd/yyyy) \*\* Sex\*\* Ethnicity:
Race:
Country of Origin / Bi-National ID
ICD Diagnosis Code † (1) ICD Diagnosis Code † (2) ICD Diagnosis Code † (3)

SECTION 5. SPECIMEN
NOTE: If the 'Date of Collection' field is not completed, the specimen will be rejected.
Date of Collection (mm/dd/yyyy) \*\* Time of Collection \*\*
Specimen Source or Type
Blood
Serum

Section 6. Chemistry Panels
Section 7. Chemistry
Section 8. HEMATOLOGY
Section 9. SPECIAL CHEMISTRY
Basic Metabolic Panel
Comp Metabolic Panel
Hepatic Function Panel
Renal Function Panel
Albumin
Alkaline Phosphatase
ALT (SGPT)
AST (SGOT)
Bilirubin, Direct
Bilirubin, Total
Blood Urea Nitrogen (BUN)
Creatinine
GGT
Glucose
Hemoglobin A1C
Magnesium

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

FOR LABORATORY USE ONLY
Specimen Received: Room Temp Cold Frozen
FREEZER REFRIGERATOR
DATE: TIME:

