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

CAP# 3024401 CLIA #45D0660644

Questions? BioThreat Team 24/7: (512) 689-5537
Chemical Threat Team 24/7: (512) 689-9945

Remember 1-1

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

SPECIMEN BARCODE
This Space for DSHS Laboratory Use Only

G-27A Emergency Preparedness Specimen Submission Form

SECTION 1. SUBMITTER

** REQUIRED

Submitter/TPI Number **	Facility / 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**.
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

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

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*	Additional ID: *e.g., CDC ID, Previous DSHS Specimen Lab Number*	

Specimen Source or Type (Required) ****

☐ Abscess (site) _____	☐ Lesion (site) _____	☐ Sputum: Induced	☐ Wound (site)_____
☐ Blood	☐ Lymph node (site) _____	☐ Sputum: Natural	☐ Other: _____
☐ Bronchial washings	☐ Nasopharyngeal Swab	☐ Throat Swab	☐ Organism isolate from (source):
☐ CSF	☐ Rectal Swab	☐ Tissue (site)_____	_____
☐ Feces / stool	☐ Serum	☐ Tracheal Aspirate	

SECTION 4. TEST REQUEST

** REQUIRED – Select One Section

Clostridium Botulinum

+++ Prior authorization required+++ Call 1-888-963-7111 for authorization from DSHS EAIDU Epidemiologist

++++ Botulism Only ++++
☐ Stool
☐ Enema
☐ Serum
☐ Wound (site) _____
☐ Gastric

Epidemiologist Approval:
_____

☐ Clostridium Botulinum
Patient symptoms (adult botulism):
☐ Blurred vision
☐ Double vision
☐ Difficulty swallowing
☐ Descending muscle weakness

Antitoxin administration date/time (if known):
_____

NOTE:
Infants: 50 g stool or 5 ml enema, no sera, ship cold
Adults: 50 g stool or 5 ml enema, ship cold, 10 ml sera min. ship cold unless >48 hours, ship frozen
Wound: 2 swabs in anaerobic transport medium, ship at room temp

Bacteriology Rule-Out/PCR

For rule-out testing. Please notify lab prior to sending samples to expedite testing (512) 776-3781

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

Molecular Studies (PCR):
☐ *Ebola* virus
☐ *Marburg* virus
☐ *Bacillus cereus* suspected of containing anthrax genes (associated with severe illness or death)
Symptoms listed in instructions

Clinical Specimen:
☐ Aerobic Culture
Organism suspected: _____

☐ Smallpox / Mpox
Smallpox Symptoms:
☐ >101F, 1-4 days prior to rash onset with headache, back ache, or abdominal pain
☐ Firm, deep-seated, well- circumscribed vesicles/pustules
☐ First lesions in the pharynx, oral mucosa
☐ Lesions in the same stage of development in any one area of the body
☐ Slow evolution of rash, 1-2 days each stage: macule, papule, vesicle
☐ Centrifugal distribution of lesions
☐ Known vaccine exposure
☐ Lesions on palms and soles
☐ Patient appears toxic

SECTION 5. ORDERING PHYSICIAN

Physician's Phone Number	Physician's Name

SECTION 6. PAYOR SOURCE

** REQUIRED

Check only one box below to indicate which DSHS Program should be billed

☐ EAIDU (1610) - Botulism
☐ BT GRANT (1[illegible]) - Everything else
☐ ZOONOSIS (1620)
☐ SUBMITTER

SECTION 7. CHEMICAL TERRORISM (CT)

NOTE: Not for Routine Analysis, Call (512) 689-9945

Matrix: ☐ Serum ☐ Blood ☐ Urine

☐ Toxic Elements
☐ Ricin/Abrin Toxin Bio Markers
☐ Cyanide
☐ Other: _____

Justification Required: _____
_____

Clinical Symptoms: _____
_____

FOR DSHS LABORATORY USE ONLY:	Specimen Received: ☐ Room Temp. ☐ Cold ☐ Frozen	NOTES: For pure culture ID and typing, please provide biochemical reactions. Each test requires separate form and specimen.