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

CAP# 3024401 CLIA #45D0660644

Questions? LabInfo@dshs.texas.gov

Specimen Acquisition: (512) 776-7598

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-2A 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 ☐ Black or African American ☐ American Indian / Native Alaskan ☐ Native Hawaiian / Pacific Islander ☐ Asian ☐ 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, receiving, 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 Info: *e.g., CDC ID, Previous DSHS Specimen Lab Number*	

Specimen Source or Type (Select One Only) **

☐ Blood ☐ CSF ☐ Serum ☐ Plasma ☐ Other: _____

REQUIRED for cold shipments, if stored in an appliance prior to shipping.

Indicate REMOVAL from: ☐ **FREEZER** ☐ **REFRIGERATOR**	**DATE** *(mm/dd/yyyy)*	***NOTE: DO NOT FREEZE Serum Separator Tube (SST) collectors (i.e. Gold Top tubes)***
	TIME *(hh:mm)* ☐ AM ☐ PM	

SECTION 8. ORDERING PHYSICIAN

**** REQUIRED**

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

SECTION 9. 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 payer will cover the testing, **the submitter will be billed.**
3. Medicare generally does not pay for screening tests-please refer to applicable Third-party payer 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. If private insurance is indicated, the required billing information below is designated with an asterisk (*).
6. **Check only one box below** to indicate whether we should bill the submitter, Medicaid, Medicare, private insurance, or DSHS program.

** REQUIRED

☐ Medicaid (2) ☐ Medicare (8)

Medicaid/Medicare #: _____

☐ Submitter (3)	☐ Immunizations (1609)
☐ BIDS (1720)	☐ Private Insurance* (4)
☐ Pub Hlth Follow Up (1608)	☐ TB Elimination (1619)
☐ HIV Prevention (1611)	☐ IDEAS/EAIDU (1610)
	☐ Zoonosis (1620)
	☐ Other:

HMO / Managed Care / Insurance Company Name *		
Address *		
City *	State *	Zip Code *
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 4. HIV/STD TESTING

☐ HIV Screen	☐ HIV RNA, NAAT Only	Justification Required: ☐ Monitoring Treatment (Plasma) ☐ Assessing Perinatal Exposure	☐ PrEP Testing Algorithm ☐ Resolve Conflicting Results	☐ Other:
☐ Syphilis Screen	☐ Syphilis RPR Only	Justification Required: ☐ Treatment Follow-up (must be same method as baseline RPR) ☐ Confirmation of positive POC test results		☐ Other:
	☐ Syphilis Confirmation by TP-PA:	Justification Required: ☐ Confirmation of positive POC test results		☐ Other:

SECTION 5. HEPATITIS TESTING

☐ Hepatitis A IgM
☐ Hepatitis A, Total Antibody
☐ Hepatitis B Core, IgM
☐ Hepatitis B Core, Total Antibody
☐ Hepatitis B Surface Antibody
☐ Hepatitis B Surface Antigen
☐ Hepatitis C Antibody
☐ Hepatitis C RNA, Quantitative NAAT Only

Justification Required:
☐ Monitoring Treatment ☐ Acute Exposure
☐ Perinatal Exposure (2-18 months)

SECTION 6. SEROLOGICAL REFERENCE TESTING

☐ Brucella, Total Antibody
☐ Chagas IgG
☐ Hantavirus IgM & IgG
☐ Measles IgM
☐ Measles IgG
☐ Mumps IgG
☐ Rocky Mountain Spotted Fever & Typhus Fever Panel IgG
☐ Rubella IgG
☐ Schistosoma IgG
☐ Strongyloides IgG

SECTION 7. CDC REFERENCE TESTS

To avoid delay of specimen processing, **you must provide patient history** by attaching it to this form or documenting patient history on the back of this page.

☐ Chagas Disease
☐ Cysticercosis
☐ Echinococcosis
☐ Fasciolasis
☐ HTLV-1
☐ Leptospirosis
☐ Paragonimiasis
☐ VRDL (CSF Only)
☐ Other:

FOR DSHS LABORATORY USE ONLY: **Specimen Received:** ☐ Room Temp. ☐ Cold ☐ Frozen