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-2B 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 epidemiological 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
Unique Identification Number ** *e.g., MRN / Alien # / Accession ID*	Comments / Additional Info *e.g., CDC ID, Previous DSHS Specimen Lab Number*	

Specimen Source / Type (Select One Only) **

☐ Abdominal Fluid	☐ Eye Swab	☐ Nasopharyngeal Swab	☐ Tissue (site)_____
☐ Abscess (site) _____	☐ Feces / stool	☐ Plasma	☐ Tracheal Aspirate
☐ Blood	☐ Gastric (Aspirate)	☐ Rectal Swab	☐ Urethral Swab
☐ Bone Marrow	☐ Gastric Contents	☐ Serum	☐ Urine
☐ Bronchial washings	☐ Lesion (site) _____	☐ Sputum: Induced	☐ Vaginal Swab
☐ Cervical Swab	☐ Lung Aspirate	☐ Sputum: Natural	☐ Wound (site)_____
☐ CSF	☐ Lymph node (site)	☐ Throat Swab	☐ Other:
☐ Endocervical Swab	_____	☐ Worm (site) _____	_____

SECTION 5. ORDERING PHYSICIAN

**** REQUIRED**

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

SECTION 6. 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 payor 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. 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)	☐ IDEAS/EAIDU (1610)
☐ BIDS (1720)	☐ Immunizations (1609)
☐ BT Grant (1719)	☐ Private Insurance* (4)
☐ Pub Hlth Follow Up (1608)	☐ TIPP (5144)
☐ HIV Prevention (1611)	☐ 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. TEST REQUEST

On tests marked with Θ: Attach prior laboratory results or relevant patient history to avoid processing delays.

On tests marked with ◆: Attach/staple a brief patient history to this form or document on the back of the page.

** REQUIRED – Select One Section

4.1 Required / Requested Submissions

- ☐ *Chlamydia trachomatis* Θ
- ☐ *Neisseria gonorrhoeae* (GC) AST Θ
- ☐ *Haemophilus influenza* Θ
  (<5 years old, invasive [sterile sites])
- ☐ *Listeria* Θ
- ☐ *Neisseria meningitidis* Θ
  (from sterile sites or purpuric lesions)
- ☐ Outbreak Stool culture Θ
- ☐ *Salmonella* Θ
- ☐ *Shigella* Θ
- ☐ Shigatoxin-producing *Escherichia coli* Θ
- ☐ *Staphylococcus aureus* Θ (VISA/VRSA)
- ☐ *Streptococcus pneumoniae* Θ
  (<5 years old, invasive [sterile sites])
- ☐ *Vibrio cholera* Θ
- ☐ *Vibrio* spp. Θ

4.2 Bacteriology

Clinical Specimen

- ☐ Aerobic Isolation
- ☐ Anaerobic Isolation
- ☐ Culture, stool
- ☐ Diphtheria Screen
- ☐ GC/CT, amplified RNA probe
- ☐ *Haemophilus* spp. isolation
- ☐ *Legionella*

Pure Culture

Organism suspected:
_____

Definitive Identification

- ☐ Anaerobic identification
  Organism Suspected:
  _____
- ☐ *Bacillus* spp.
- ☐ *Campylobacter* spp.
- ☐ Enteric bacteria
- ☐ Gram Negative Rod
- ☐ Gram Positive Rod
- ☐ *Legionella* spp.
- ☐ *Neisseria* spp.
- ☐ *Staphylococcus* spp.
- ☐ *Streptococcus* spp.
- ☐ Other: _____

4.3 Parasitology

- ☐ *Cryptosporidium* spp. Exam
- ☐ *Cyclospora* spp. Exam
- ☐ Fecal Ova and Parasite Exam
- ☐ **Malaria or Blood Parasite Exam ◆**
- ☐ **Schistosoma or Urine Parasite Exam ◆**
- ☐ Worm Identification ◆
- ☐ Other:

_____

4.4 Molecular Studies

PCR:

- ☐ *Cryptosporidium* subtyping
- ☐ *Cyclospora* identification
- ☐ *Plasmodium* identification
- ☐ Norovirus

Epidemiology Request:

- ☐ WGS

Organism: _____

Please indicate in Section 2 if WGS request is related to Outbreak Association or Surveillance

FOR DSHS LABORATORY USE ONLY:

Specimen Received: ☐ Room Temp. ☐ Cold ☐ Frozen