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-2E Specimen Submission Form

SAMPLE DO NOT USE

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 5. ORDERING PHYSICIAN

Physician's NPI Number	Physician's Name

SECTION 6. PAYOR SOURCE

☒ CDC Special Project (14)

Comments/Notes:
Reflex testing will be performed when necessary

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

⊖ Indicates epidemiologic 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) **

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

SECTION 7. COLLECTION SITE

**REQUIRED

Collection Site Name**	
Collection Site Sample Number**	Zip Code**

Collection Site Infection Control Contact Name

Collection Site Infection Control Contact Phone Number

CLIA#

SECTION 4. TEST REQUEST – Select one box (isolate or colonization) and one organism test

BOX 1

☐ **Isolate Testing**

****REQUIRED:** Attach previous lab results or write previous results on back of form

Print the name of the organism: ______________________

Select ONE isolate test below:

- ☐ *Candida* identification by MALDI (*Candida* susceptibility may be performed)
- ☐ CRAB: Carbapenem Resistant *Acinetobacter*
- ☐ CRE: Carbapenem Resistant Enterobacterales
- ☐ CRPA: Carbapenem Resistant *Pseudomonas aeruginosa*

BOX 2

☐ **Colonization Screening ONLY**

NOTE: Only performed with approval from coordinating regional epidemiologist

****REQUIRED If Box 2 is checked:** Select **ONE** screening organism below:

- ☐ *Candida auris*
- ☐ CRAB: Carbapenem Resistant *Acinetobacter*
- ☐ CRE: Carbapenem Resistant Enterobacterales
- ☐ CRPA: Carbapenem Resistant *Pseudomonas aeruginosa*
- ☐ Other: ______________________

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