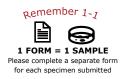


Questions? LabInfo@dshs.texas.gov Specimen Acquisition: (512) 776-7598

CAP# 3024401

Texas Department of State Health Services CLIA #45D0660644



SPECIMEN BARCODE

This Space for DSHS Laboratory Use Only

G-2E Specimen Submission Form

SECTION 1. SUBMITTER					SECTION 5. ORDERING PHYSICIAN			
	Submitter/TPI Number **	Submitter Name*	*			Physician's NPI Number	Physician's Name	
REQUIRED								
	NPI Number ** Address **				SECTION 6. PAYOR SOURCE			
	City ** State ** Zip Code **					⊠ CDC Special Fisienter4)		
** RE	«							
*	Phone Number ** Fax ** Contact Name and/or Email #			Address				
						Comments/Notes:		
	SECTION 2. PATIENT						ed when ecessary	
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#. Last Name ** First Name **							
** REQUIRED	Last Name							
	Address ** Phone Nur				Imber			
	City ** State **		Zip Code ** Pregnar		? No 🗆 Unknown			
			1 Toghant.					
	DOB (mm/dd/yyyy) ** Sex** Hispanic Un own On-Hispanic							
Uwhite Alexan Acian Olidicates								
Race: Black or African American Native Hawaiian / Pacific Islander Other epidemiologic interest sample/test is reliad to a								
Diagnosis / Symptoms Θ Risk □ Inpatient epidemiology invest store and an epidemiology invest store, complete relevant field								
Date of Onset O								
ICD I	Diagnosis Code † (1) ICD D	iagnosis Code † (2)	ICD Diagnosis Co		http://d.help.in.processing, http://and.billing.of.this cime			
				spe	Cirrie			
SECTION 3. SPECIMEN NOTE: If the 'Date of Collection' field is not completed, the specimen will be specied.								
** REQUIRED	Date of Collection (mm/dd/yyyy) ** Time of Collection ** Collected by:				/:	SECTION 7. CO	OLLECTION SITE	
					**REQUIRED			
	Unique Identification Number ** Comments or Action ID: e.g., MRN / Alien # / Accession ID g., CDC ID, Previous Dues Specimen Lab Nu				Number	Collection	Site Name**	
						Collection Site Sample Num	ber** Zip Code**	
	Specimen Source or ype (Select One Only) **							
	Abscess (site) Gastric (Aspirate)				Throat Swab Tissue (site)	Collection Site Infection Control Contact Name		
	Blood Gasta Contents Rectal Swab Bone Marrow Lesion (ne) Serum Bronchial washings Lum Aspin Sputum: Induced Cervical Swab Lym in node (ne) Sputum: Natural CSF Swab Site D				Tracheal Aspirate Urethral Swab	rethral Swab Collection Site Infection Control Contact Phone Number rine		
				ced 🗆	Urine			
				Wound (site) Other: :	CLIA#			
Endocervical Sw2								
SECTION 4. TEST REQUEST – Select one box (isolate or colonization) and one organism test								
BOX 1					BOX 2			
**REQUIRED: Attach previous lab results or write previous results on back of form NOTE: Only performed with approval from coordinating regional epidemiologia								
Print the same tibe organism:							corconing organism	
Select ON Collare test below: **REQUIRED If Box 2 is checked: Select ONE screening organism below:							screening organism	
□ Candida identification by MALDI (Candida susceptibility may be					□ Candida auris			
	erivrmed) DCRAB: Carbapenem	Resistant Acine	obacter	CRAB: Carbapenem Resistant <i>Acinetobacter</i>				
CRE: Carbapenem Resistant Enterobacterales					 CRE: Carbapenem Resistant Enterobacterales CRPA: Carbapenem Resistant <i>Pseudomonas aeruginosa</i> Other: 			
CRPA: Carbapenem Resistant <i>Pseudomonas aeruginosa</i>								
FOR DSHS LABORATORY USE ONLY: Specimen Received: Room Temp. Cold Frozer								
					5			

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