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

(956) 364-8746 FAX: (956) 412-8794

F40-D Emergency Preparedness Specimen Submission Form (Jan 2022)

CLIA #45D0503753 CAP #2148801

www.dshs.texas.gov/lab/so_tx_lab

Place DSHS Bar Code Label / Address-O-Graph Here

Section 1. SUBMITTER INFORMATION – (** REQUIRED)

Submitter/TPI Number ** | Submitter Name **

NPI Number ** | Address **

City ** | State ** | Zip Code **

Phone ** | Contact

Fax ** | Clinic Code

Section 2. PATIENT INFORMATION -- (** REQUIRED)

NOTE: **Patient name** is **REQUIRED & MUST** match name on this form, Medicare/Medicaid card, & specimen container.

Last Name ** | First Name ** | MI

Address ** | Telephone Number

City ** | State ** | Zip Code ** | Country of Origin / Bi-National ID #

DOB (mm/dd/yyyy) ** | Sex ** | Unique Number | Pregnant? ☐ Yes ☐ No ☐ Unknown

Race: ☐ White ☐ Black or African American ☐ American Indian / Native Alaskan ☐ Asian ☐ Native Hawaiian / Pacific Islander ☐ Other

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Date of Collection ** **REQUIRED)** | Time of Collection ☐ AM ☐ PM | Collected By

Medical Record # | Alien # / CUI / CDC ID | Previous DSHS Specimen Lab Number

ICD Diagnosis Code ** (1) | ICD Diagnosis Code ** (2) | ICD Diagnosis Code ** (3)

Date of Onset | Diagnosis / Symptoms | Risk

☐ Inpatient ☐ Outpatient ☐ Outbreak association: ☐ Surveillance

Section 3. SPECIMEN SOURCE OR TYPE -- (**REQUIRED)

- ☐ Abscess (site) _____
- ☐ Blood
- ☐ Bone marrow
- ☐ Bronchial washings
- ☐ CSF
- ☐ Eye
- ☐ Feces/stool
- ☐ Gastric
- ☐ Lesion (site)_____
- ☐ Lymph node (site)_____
- ☐ Nasopharyngeal
- ☐ Rectal swab
- ☐ Serum
- ☐ Sputum: Induced
- ☐ Sputum: Natural
- ☐ Throat swab
- ☐ Tissue (site) _____
- ☐ Wound (site) _____
- ☐ Other:

Section 4. BACTERIOLOGY RULE-OUT

NOTES: For rule-out testing. Please notify lab prior to sending samples for expedite testing at (956) 364-8369.

Clinical specimen:

☐ Aerobic Culture
Organism suspected: _____

Definitive Identification:

- ☐ Bacillus anthracis
- ☐ Brucella spp.
- ☐ Burkholderia mallei/pseudomallei
- ☐ Francisella tularensis
- ☐ Yersinia pestis

NOTES: For pure culture ID and typing, please provide biochemical reactions on reverse side of form or attach copy of biochemistry printout. Each test block (ex. Bacteriology) requires a separate form and specimen. Please see the form's instructions for details on how to complete this form. Visit our web site at http://www.dshs.state.tx.us/lab/. NOTE:All dates must be entered in mm/dd/yyyy format.

Section 5. ORDERING PHYSICIAN INFORMATION – (** REQUIRED)

Ordering Physician's NPI Number ** | Ordering Physician's Name **

Section 6. PAYOR SOURCE – (REQUIRED)

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 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 below.
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.

☐ Medicaid (2) ☐ Medicare (8)

Medicaid/Medicare #: _____

☐ Submitter (3) ☐ Private Insurance (4)

☐ BIDS (1720) ☐ Other: _____

☐ BT Grant (1719)

☐ IDEAS (1610)

☐ Zoonosis (1620)

HMO / Managed Care / Insurance Company Name *

Address *

City * | State * | Zip Code *

Responsible Party *

Insurance Phone Number * | Responsible Party's Insurance ID Number *

Group Name | Group Number

"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, Laboratory Services Section."
Signature of patient or responsible party.

Signature * Date *

Section 7. ANTIBODY TESTING

☐ COVID-19 IgG/IgM

Section 8. MOLECULAR

☐ Multiplex test
☐ Zika PCR (Urine Only)

☐ Zika, Dengue, and/or Chikungunya

NOTE: Serology, PCR, or both will be performed at DSHS and the testing methodology and specific viruses approved for testing will be based on clinical symptoms and epidemiological criteria. In some instances, specimens may be forwarded to CDC for further testing

*****FOR DSHS USE ONLY*****

Testing Criteria? ☐ Met ☐ Not Met

PCR	Serology	Initials	Date
☐ C	☐ C		
☐ D	☐ D		
☐ Z	☐ Z		

▲ REQUIRED for cold/frozen shipments, if stored in an appliance

Indicate removal from:

☐ FREEZER ☐ REFRIGERATOR

DATE: | TIME:

FOR LABORATORY USE ONLY

Specimen Received: ☐ Room Temp ☐ Cold ☐ Frozen