



**G-23 Food Sample Specimen Submission Form**  
 CAP# 3024401 CLIA# 45D0660644 (SEP 2015)  
 Laboratory Services Section, MC-1947  
 P. O. Box 149347, Austin, Texas 78714-9347  
 Courier: 1100 W. 49<sup>th</sup> Street, Austin, Texas 78756  
 (888) 963-7111 x7318 or (512) 776-7318  
 http://www.dshs.state.tx.us/lab

**\*\*\*For DSHS Use Only\*\*\***  
**Place DSHS Bar Code Label Here**

Specimen Acquisition: (512) 776-7598

**ONE FORM PER SPECIMEN REQUIRED**

**Section 1. SAMPLE INFORMATION -- (\*\*REQUIRED)**

Reason for Testing

Routine

Food Borne Outbreak  
 (please complete the outbreak section to the right if this box is checked)

**Section 3. PAYOR SOURCE -- (REQUIRED)**

----- YOU MUST CHECK THE APPROPRIATE BOX-----

IDEAS

Sample Description:

**Section 4. OUTBREAK LINKED SAMPLES**

Outbreak Location: (City) \_\_\_\_\_ PH Region \_\_\_\_\_

Date of Collection ** (REQUIRED)	Time of Collection **	<input type="checkbox"/> AM**	Collected By **
		<input type="checkbox"/> PM**	

Brand: \_\_\_\_\_

Facility/ Submitter Name \_\_\_\_\_

Code: \_\_\_\_\_

Sample Number: \_\_\_\_\_ Submitter Number: \_\_\_\_\_

Product: \_\_\_\_\_

Contact Phone # \_\_\_\_\_ Contact Fax # \_\_\_\_\_

Seal: \_\_\_\_\_

**Section 2. TESTING INFORMATION**

**\*\*\*\*\* EACH TEST REQUIRES ≥ 4 oz SAMPLE-REPEAT, EACH TEST\*\*\*\*\***

Please Indicate Desired Testing

<input type="checkbox"/> Bacillus identification	<input type="checkbox"/> Salmonella identification
<input type="checkbox"/> Bacillus enumeration, MPN	<input type="checkbox"/> Shigella identification
<input type="checkbox"/> Campylobacter identification	<input type="checkbox"/> Staphylococcus identification
<input type="checkbox"/> Clostridium perfringes identification	<input type="checkbox"/> Staphylococcus enterotoxin detection
<input type="checkbox"/> Cronobacter sakazakii	<input type="checkbox"/> Standard Plate Count
<input type="checkbox"/> E.coli 0157 identification	<input type="checkbox"/> Yeast & Mold enumeration (MPN)
<input type="checkbox"/> E.coli enumeration (MPN)	<input type="checkbox"/> Yersinia identification
<input type="checkbox"/> E.coli non-0157 STEC	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Listeria identification	

Size: \_\_\_\_\_

Condition: \_\_\_\_\_

Remarks: \_\_\_\_\_

Brief description of patient's symptoms: \_\_\_\_\_

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

Date Received \_\_\_\_\_

**REFLEX & REFERENCE TESTING:**

Please note that additional testing procedures (i.e., reflex testing) will be performed when necessary and clinically indicated by the initial lab test results. Reflex testing will be billed to the appropriate payor in addition to the original test requested. This is particularly applicable to microbiology testing and other laboratory testing requiring confirmation or further diagnostic work.

All reference tests will be billed to the submitter at the prevailing reference laboratory's price with the addition of a handling fee.

Details of test and specimen requirements can be found in the Laboratory Services Section's web site at <http://www.dshs.state.tx.us/lab/>.