



**G-27A Emergency Preparedness Specimen Submission Form (SEP 2014)**  
 CAP# 3024401 CLIA #45D0660644  
 Laboratory Services Section, MC-1947  
 P. O. Box 149347, Austin, Texas 78714-9347  
 Courier: 1100 W. 49th 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**

**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 \*\*      SSN      Pregnant?  
 Yes     No     Unknown  
 Race:  White     Black or African American     Hispanic  
 American Indian / Native Alaskan     Asian     Non-Hispanic  
 Native Hawaiian / Pacific Islander     Other     Unknown  
 Ethnicity:  Non-Hispanic  
 Unknown

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

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 4. CLOSTRIDIUM BOTULINUM**

Clostridium Botulinum      ++++ **Prior authorization required.** ++++  
 Patient symptoms (adult botulism):  
 Blurred vision     Double vision    Call (512) 776-7111 for authorization from a DSHS epidemiologist  
 Difficulty swallowing    **Authorization Code:**  
 Descending muscle weakness    **Authorization Authority:**  
 Descending symmetric paralysis  
 Stool    ++++ **Botulism Only** ++++     Serum     Wound (site) \_\_\_\_\_  
 NOTES: Infants: 5-10g stool, no sera, ship cold. Adults: 5-50g stool, 5 ml sera min, ship cold.  
Wounds: swab on anaerobic transport medium, ship cold

**Section 6. ORDERING PHYSICIAN INFORMATION - (\*\* REQUIRED)**

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

**Section 7. 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 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 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)       TB Elimination (1619)  
 BT Grant (1719)       Title X (12)  
 HIV / STD (1608)       Title XX (13)  
 IDEAS (1620)       TX CLPPP (9)  
 Immunizations (1609)       Zoonosis (1620)  
 Refugee (7)       Other: \_\_\_\_\_

**Section 8. CHEMICAL TERRORISM (CT)**

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 5. BACTERIOLOGY RULE-OUT / PCR**

NOTES: For rule-out testing. Please notify lab prior to sending samples to expedite testing (512) 776-3781.  
**Clinical specimen:**  
 Aerobic Culture      **Molecular Studies (PCR):**  
 Organism suspected: \_\_\_\_\_     Coxiella burnetii  
 Smallpox  
**Definitive Identification:**  
 Bacillus anthracis      **Smallpox Symptoms:**  
 Brucella spp.       >101F, 1-4 days prior to rash onset with headache, back ache, or abdominal pain       Centrifugal distribution of lesions  
 Burkholderia mallei/pseudomallei       Firm, deep-seated, well-circumscribed vesicles/pustules       Known vaccine exposure  
 Francisella tularensis       First lesions in the pharynx, oral mucosa       Lesions on palms and soles  
 Yersinia pestis       Lesions in the same stage of development in any one area of the body       Patient appears toxic  
 Slow evolution of rash, 1-2 days each stage: macule, papule, vesicle  
 Other: \_\_\_\_\_

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/>.  
 @ = Provide patient history on reverse side of form to avoid delay of specimen processing.      NOTE: All dates must be entered in mm/dd/yyyy format.

## G-27A Emergency Preparedness Specimen Submission Form Instructions

For mailing and specimen packaging information, visit DSHS Laboratory Services Section's web page at <http://www.dshs.state.tx.us/lab/>.

The specimen submission form **must** accompany each specimen.  
The patient's name listed on the specimen **must** match the patient's name listed on the form.  
If the Date of Collection field is not completed or is inaccurate, the specimen will be rejected.

### **Section 1. SUBMITTER INFORMATION**

All submitter information that is required is marked with double asterisks (\*\*).

**Submitter/TPI number, Submitter Name and Address:** The submitter/TPI number is a unique number that the Texas Department of State Health Services (DSHS) Laboratory Services Section assigns to each of our submitters. To obtain a Texas Provider Identifier (TPI) number, contact Texas Medicaid and Healthcare Partnership (TMHP) at 1-800-925-9126.

To request a DSHS Laboratory Services Section submitter number, a master form, or to update submitter information, please call (888) 963-7111 x7578 or (512) 776-7578, or fax (512) 776-7533 or visit [http://www.dshs.state.tx.us/lab/mrs\\_forms.shtm#email](http://www.dshs.state.tx.us/lab/mrs_forms.shtm#email).

**NPI Number:** Indicate the facility's 10-digit NPI number. All health care providers must use the National Provider Identifier (NPI) number. To obtain an NPI number, contact the National Plan and Provider Enumeration System (NPPES) toll free at (800) 465-3203 or via their web site at <https://nppes.cms.hhs.gov/NPPES/Welcome.do>.

**Contact Information:** Indicate the name, telephone number, and fax number of the person to contact at the submitting facility in case the laboratory needs additional information about the specimen/isolate.

**Clinic Code:** Please provide, if applicable. This is a code that the submitter furnishes to help them identify which satellite office submits a specimen and to help the submitter identify where the lab report belongs, if the submitter has a primary mailing address with satellite offices.

### **Section 2. PATIENT INFORMATION**

Complete all patient information including date of collection, time of collection, previous DSHS specimen lab number, last name, first name, middle initial, address, city, state, zip code, country of origin, telephone number, date of birth (DOB), date and time of collection, collected by, sex, social security number (SSN), pregnant, race, ethnicity, medical record number, ICD diagnosis code, date of onset, diagnosis/symptoms, risk, and mark either inpatient/outpatient, outbreak association, and/or surveillance.

**NOTE: The patient's name listed on the specimen must match the patient's name listed on the form.**

Information that is required to bill Medicare, Medicaid, or private insurance has been marked with double asterisks (\*\*). These fields must be completed. You may use a pre-printed patient label.

**Patient Name:** If patient is covered by Medicaid, Medicare, or Private Insurance, the name on the specimen form and specimen **must** match the name on the Medicaid, Medicare and insurance card, respectively.

**Date of birth (DOB):** Please list the date of birth. If the date of birth is not provided, the specimen may be rejected.

**Pregnant:** Indicate if female patient is pregnant by marking either Yes, No, or Unknown.

**Date of Collection/Time of Collection:** Indicate the date and time the specimen was collected from the patient or other source. Do not give the date the specimen was sent to DSHS. **IMPORTANT: If the Date of Collection field is not completed or is inaccurate, the specimen will be rejected.**

**Collected By:** Clearly indicate the individual who collected the specimen.

**Medical Record # / Alien # / CUI:** Provide the identification number for matching purposes. CUI is the Clinic Unique Identifier number.

**Previous DSHS Specimen Lab Number:** If this patient has had a previous specimen submitted to the DSHS Laboratory, please provide the DSHS specimen lab number.

**ICD Diagnosis Code(s), Country of Origin, Date of Onset, Diagnosis/Symptoms, and Risk (if applicable):** Indicate the diagnosis code or findings that would help in processing, identifying, and billing of this specimen/isolate. If the patient's country of origin is not the U.S., then please provide the patient's country of origin.

**Inpatient or Outpatient (if applicable):** Indicate if the patient is currently admitted to a hospital (required for TB patients).

**Outbreak/Surveillance (if applicable):** Tell us whether the specimen/isolate is part of an outbreak or cluster, or if the specimen is for routine surveillance. If the specimen is being submitted because of an outbreak, write in the associated name of the outbreak next to the outbreak box.

### **Section 3. SPECIMEN SOURCE OR TYPE**

**Specimen Source or Type:** Indicate the kind of material you are submitting or the source of the specimen or isolate.

For specimens other than those listed, check the "Other" box and write in the site and source selected from the TB Elimination Division's list of Anatomic Sites and Corresponding Specimen Sources, which can be obtained from your local or regional health department.

++++ **Botulism Only** ++++: Use this only for specimens submitted for *Clostridium botulinum* testing. For infant testing send 5g to 10g stool, do **not** send sera. For adult testing send a minimum of 5ml sera and/or 5g to 50g stool. For wound testing send a swab in anaerobic transport medium. Ship all samples cold. Specimen source is a required field for botulism testing.

**TEST**

**Test Requested:** You **MUST** check or specify the specific test(s) to be performed by the DSHS Laboratory Services Section. Each test block requires a separate form AND a separate specimen. Examples of separate blocks are “Clostridium botulinum” “Bacteriology” or “Chemical Terrorism”. For specific test instructions, see the Laboratory Services Section Manual of Reference Services. To cancel a test that is marked in error on the form, mark one line through the test name, write “error” and initial.

**Section 4. CLOSTRIDIUM BOTULINUM**

++++ **Prior authorization required** ++++: Before specimens can be submitted for *Clostridium botulinum* testing, a DSHS botulism epidemiologist consult is required. The physician should call the switchboard at (512) 776-7111 to talk to an DSHS epidemiologist for a consult. An authorization code and authority name will then be supplied if the epidemiologist approves the testing. Please write the authorization code and authorization authority name in the appropriate lines on the form. Check the *Clostridium botulinum* box and check the appropriate patient symptoms. Make sure to include both a contact phone number and pager number in Section 6 “Ordering Physician Information” to facilitate communication between the ordering physician and the botulism epidemiologist(s).

**Section 5. BACTERIOLOGY RULE-OUT / PCR**

This testing is to rule-out specific biothreat agents listed on form G-27A. Do not use this form for regular bacteriological testing. For regular bacteriological testing, use the G-2B form. Please notify the laboratory at (512) 776-3781 prior to sending samples to expedite testing.

**Under the “Bacteriology” section of the form:**

1. Under “Clinical specimen:”
  - a. Check the box marked “Aerobic Culture”, if the specimen is a clinical sample. Under “Organism suspected”, please hand write the organism suspected for rule-out purposes. For botulism testing complete “Section 4. Clostridium botulinum” do not use Section 5. “Bacteriology”.
2. Under “Definitive Identification:”
  - a. If a suspected agent is isolated and a pure culture is being submitted, please check the appropriate organism identification box for rule-out purposes.
3. Under “Molecular Studies (PCR):”
  - a. Check the box corresponding to the suspected organism. For suspect smallpox cases, please check the appropriate smallpox symptom(s) boxes.

**Section 6. ORDERING PHYSICIAN INFORMATION**

**Ordering Physician’s Name and NPI Number:** Give the name of the physician and the physician’s NPI number. **This information is required to bill Medicaid, Medicare, and insurance.** Make sure to include both a contact phone number and pager number in Section 6 “Ordering Physician Information” for botulism samples to facilitate communication between the ordering physician and the botulism epidemiologist(s).

**Section 7. PAYOR SOURCE**

**THE SUBMITTER WILL BE BILLED**, if the required billing information is not provided, is inaccurate, or if multiple payor boxes are checked.

**Indicate the party that will receive the bill by marking only one box.**

**Please do not use this form for THSteps or medical check-ups; use the G-THSTEPS form.**

If selecting a DSHS Program:

- If you are contracting and/or approved by a DSHS program to provide services that require laboratory testing, please indicate which program. For program descriptions, see the Laboratory Services Section’s Manual of Reference Services located on the web site at [http://www.dshs.state.tx.us/lab/prog\\_desc.htm](http://www.dshs.state.tx.us/lab/prog_desc.htm).
- For BIDS (Border & Infectious Disease Surveillance), CLPPP or IDEAS, check the appropriate box. Please check the “Other” box and list the program’s name in the space provided if necessary.
- **Do NOT check a DSHS program as a Payor Source if the patient has Medicaid, Medicare, or private insurance.**

If selecting Medicaid or Medicare:

- Mark the appropriate box.
- Write in the Medicaid or Medicare number.
- If the patient name on the form does not match the name on the Medicaid/Medicare card, the submitter will be billed.
- Patient’s DOB and address must be provided.

If selecting Private Insurance:

- Mark the appropriate box.
- Complete all fields on the form that have an asterisk (\*).
- If the private insurance information is not provided on the specimen form or is inaccurate, the submitter will be billed.
- Patient’s DOB and address must be provided.

**HMO / Managed Care / Insurance Company:** Print the name, address, city, state, and zip code of the insurance company to be billed. If all insurance information is not provided on the specimen form, the submitter will be billed. **NOTE:** The DSHS laboratories are not an in-network CHIP or CHIP Perinate provider. If CHIP or CHIP Perinate is indicated, the submitter will be billed.

**Responsible Party:** Print the Last Name, First Name of the responsible party, the insurance ID number, insurance company’s phone number, group name, and group number.

**Signature and Date:** Have the responsible party sign and date to authorize the release of their information, if DSHS is to bill their insurance or HMO.

**Section 8. CHEMICAL TERRORISM**

In the event of a suspected chemical terrorism event, blood and urine samples may be sent for chemical threat testing. This is not for routine testing of blood and urine. Justification is a required field and must be completed in order for samples to be tested. Please notify the laboratory at (512) 689-9945 prior to sending samples to expedite testing and to obtain a justification code.

**REFLEX & REFERENCE TESTING:**

Please note that additional testing procedures (i.e., reflex testing) will be performed at the request of the submitter. 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.

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For specific test instructions and information about tube types, see the Laboratory Services Section Manual of Reference Services on our web site at <http://www.dshs.state.tx.us/lab/>.