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

Specimen Acquisition: (512) 776-7598

G-2B Specimen Submission Form (Jan 2020)

CAP# 3024401 CLIA #45D0660644

www.dshs.texas.gov/lab

For DSHS Use Only

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 MUST** match name on this form, Medicare/Medicaid card, & specimen container.
Specimen must have two (2) identifiers that match this form.

Last Name **	First Name **	MI
Address **	Telephone Number	
City **	State ** / Zip Code **	Country of Origin / Bi-National ID # Θ
DOB (mm/dd/yyyy) **	Sex	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 Θ	Diagnosis / Symptoms Θ	Risk

☐ Inpatient ☐ Outpatient ☐ Outbreak association: Θ ☐ Surveillance Θ

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

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

Section 4. PARASITOLOGY (MORPHOLOGICAL EXAM)

- ☐ Cryptosporidium/Cyclospora Exam
- ☐ Fecal Ova and Parasite Exam
- ☐ Malaria/Blood Parasite Exam @
- ☐ Schistosoma/Urine Parasite Exam @
- ☐ Worm Identification @
- ☐ Other :

Include brief patient history on tests marked with @

Section 5. BACTERIOLOGY

Clinical specimen:

- ☐ Aerobic isolation
- ☐ Anaerobic isolation
- ☐ Culture, stool
- ☐ Diphtheria Screen
- ☐ GC/CT, amplified RNA probe
- ☐ Haemophilus, isolation

Definitive Identification:

- ☐ Bacillus
- ☐ Campylobacter
- ☐ Enteric Bacteria
- ☐ Gram Negative Rod
- ☐ Gram Positive Rod
- ☐ Legionella
- ☐ Neisseria
- ☐ Pertussis / Bordetella
- ☐ Staphylococcus
- ☐ Streptococcus
- ☐ Other:_____

Pure culture:

- ☐ Anaerobic identification
- ☐ Organism suspected: _____

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)
- ☐ BIDS (1720)
- ☐ BT Grant (1719)
- ☐ HIV / STD (1603)
- ☐ IDEAS (1610)
- ☐ Immunizations (1609)
- ☐ Private Insurance (4)
- ☐ TIPP (5144)
- ☐ Zoonosis (1620)
- ☐ Other: _____

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 8. MOLECULAR STUDIES

PCR:

- ☐ Bordetella Pertussis, Parapertussis, and Bordetella holmesii detection, real-time
- ☐ Cyclospora Identification
- ☐ Malaria identification
- ☐ Norovirus

Section 9. REQUIRED/REQUESTED SUBMISSIONS

- ☐ Corynebacterium diphtheriae Θ
- ☐ Haemophilus,**influenza** (from sterile sites and <5 years old) Θ
- ☐ Listeria Θ
- ☐ Neisseria meningitidis(from sterile sites or purpuric lesions) Θ
- ☐ Outbreak stool culture Θ
- ☐ Salmonella Θ
- ☐ Shigella Θ
- ☐ Shigotoxin-producing Escherichia coli
- ☐ Staphylococcus aureus (VISA/VRSA) Θ
- ☐ Streptococcus pneumoniae(from sterile sites and <5 years old) Θ
- ☐ Vibrio cholera Θ
- ☐ Vibrio sp. Θ

Include patient history on reverse side of form to avoid delay of specimen processing on test marked with Θ

NOTES: All dates must be entered in mm/dd/yyyy format For culture ID or typing, please provide biochemical reactions on reverse side of form or attach copy of biochemistry printout. Each test section (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.texas.gov/lab/

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