Texas Department of State Health Services

Specimen Acquisition: (512) 776-7598

G-2V Virology Specimen Submission Form (Jan 2020) Rev. v.1

CAP# 3024401 CLIA #45D0660644

www.dshs.texas.gov/lab

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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** on specimen **MUST** match name on this form & Medicaid/Medicare card.
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 #
DOB (mm/dd/yyyy) **	Age**	Sex	Pregnant? ☐ Yes ☐ No ☐ Unknown

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

☐ Blood
☐ Bronchoalveolar Lavage
☐ Buccal swab
☐ CSF
☐ Nasopharyngeal swab
☐ Nasal Swab

☐ Serum:
Acute date: ____/_____/_____
Conv. date: ____/_____/_____

☐ Sputum: Induced
☐ Sputum: Natural
☐ Throat swab
☐ Urine
☐ Other: _______________

Section 4. VIROLOGY

☐ Influenza surveillance {Influenza PCR}
Vaccine received: ☐ Yes ☐ No
Date vaccine received: ____________________
Travel history (if known): ____________________

☐ COVID-19 (SARS-CoV-2) PCR

☐ Measles PCR
Vaccine received: ☐Yes ☐ No
Date vaccine received: ____________________
Travel history (if known): ____________________

☐ Mumps PCR
Vaccine received: ☐Yes ☐No
Date vaccine received: ____________________
Travel history (if known): ____________________

☐ MERS Coronavirus (Novel coronavirus)
++++ ***Prior authorization required***. ++++
Call Infectious Disease (512) 776-7676 for authorization

☐ Other: ____________________

Note: By checking the Influenza Surveillance or COVID-19 PCR test request box, submitters authorize DSHS to test for Flu and/or COVID as resources allow.

▲ REQUIRED for cold/frozen shipments, if stored in an appliance prior to shipping.

Indicate removal from: ☐FREEZER ☐REFRIGERATOR	DATE	TIME (hr min) ☐ AM ☐ PM

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 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)
☐ IDEAS (1610)
☐ Immunizations (1600)
☐ Private Insurance (4)
☐ Zoonosis (1620)
☐ Other: _______________

HMO / Managed Care / Insurance Company Name *		
Address *		
City *	State *	Zip Code *
Responsible Party (Last Name, First Name) *		
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. ARBOVIRUSES

☐ Zika, Dengue, and/or Chikungunya
☐ Arbovirus IgM (West Nile, St. Louis Encephalitis) ▲
☐ Other: ____________________

NOTE: DSHS may test for Zika, Dengue, Chikungunya, West Nile (WN), St. Louis Encephalitis (SLE) and/or other emerging arboviruses, as needed. Serology, PCR, or both will be performed at DSHS and the testing methodology and specific viruses analyzed will be based on clinical symptoms and current epidemiological testing criteria. Testing may initially be performed to identify a specific suspected virus or viruses. Reflex testing may be ordered based on initial results and/or approval of additional testing. In some instances, specimens may also be forwarded to CDC for further testing.

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Testing Criteria? ☐ Met ☐ Not Met

PCR:	Serology:	Initials:	Date:
☐ C ☐ D ☐ Z	☐ C ☐ D ☐ Z		
☐ Other: __________			

DSHS Lab Staff Notes:

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Specimen Received: ☐ Room Temp. ☐ Cold ☐ Frozen

SAMPLE DO NOT USE