



Texas Department of State Health Services

G-THSTEPS Specimen Submission Form (Jan 2020)
CAP# 3024401 CLIA #45D0660644
www.dshs.texas.gov/lab

For DSHS Use Only

FOR TEXAS HEALTH STEPS SPECIMENS ONLY !!!

IS THIS LABORATORY SUBMISSION PART OF THE THSTEPS MEDICAL CHECKUP OR FOLLOW-UP VISIT? Yes No

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
Specimen must have two (2) identifiers that match this form
If the Date of Collection field is not completed, the specimen will be rejected

Section 1. SUBMITTER INFORMATION (** REQUIRED)

Submitter/TPI Number, Submitter Name, NPI Number, Address, City, State, Zip Code, Phone, Contact, Fax, Clinic Code

Section 4. ORDERING PHYSICIAN INFORMATION (** REQUIRED)

Ordering Physician's NPI Number, Ordering Physician's Name

Section 5. 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. If the Medicaid number is not provided or is inaccurate, the submitter will be billed.
4. Please write the Medicaid number in the space provided below.

Section 2. PATIENT INFORMATION (** REQUIRED)

NOTE: Patient name on specimen is MUST match name on this form & Medicaid 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

Section 6. HL

- Hemoglobin
Lead

If this is a follow-up due to a previous abnormal or elevated result, mark "Yes" below and provide previous DSHS specimen lab number in Section 2.

DOB, Sex, SSN, Pregnant?, Race, Ethnicity

Section 7. STD

- Gonorrhea/Chlamydia (GC/CT), Amplified RNA probe
HIV
Syphilis

NOTE: DO NOT freeze Serum Separator Tube (SST) collectors (i.e. Gold Top tubes)

Date of Collection, Time of Collection, Medical Record #, CDC ID, Previous DSHS Specimen Lab Number

Section 8. CHEMISTRIES

- Cholesterol
High-density lipoprotein (HDL)
Lipid panel
Glucose, Random
Glucose, Fasting

NOTE: DO NOT FREEZE Serum Separator Tube (SST) collectors (i.e. Gold Top tubes)

ICD Diagnosis Code

Section 3. SPECIMEN TYPE

Blood: Capillary, Venous, Endocervical; Plasma, Serum, Urethral; Urine, Vaginal, Other

NOTES: All dates must be entered in mm/dd/yyyy format. Please see the form's instructions for details on how to complete this form. Details of test procedure requirements can be found in the Laboratory Testing Services Manual. Visit our website at http://www.dshs.texas.gov/lab/

▲ = If stored in an appliance prior to shipping, document date & time specimens were removed from FREEZER / REFRIGERATOR in the lower right-hand box.

For assistance or questions, email ClinicalChemistry@dshs.texas.gov

REQUIRED for cold shipments, if stored in an appliance prior to shipping. Indicate REMOVAL from:

- FREEZER
REFRIGERATOR

DATE (mm/dd/yyyy), TIME (hr min), AM, PM

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Comments: Specimen Received: Room Temp., Cold, Frozen