TEXAS Department of State Health Services

Specimen Acquisition: (512) 776-7598

G-2E **Specimen Submission Form (July 2018)**

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.texas.gov/lab

For DSHS Use Only

Place Texas DSHS Bar Code Label Here

NOTE: This form is for CDC Special Projects on antibiotic resistant organisms ONLY!!!

Facilities outside of the State of Texas must contact their State Epidemiologist or Healthcare Acquired Infection (HAI) Coordinator for pre-approval to submit.

Mountain Region Participating States: Arizona, Colorado, Idaho, Montana, New Mexico, Utah, and Wyoming.

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 & specimen container. Specimen must have two (2) patient-specific 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) **	Sex	SSN	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 **	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

☐ Outbreak association: ☐ Surveillance

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

☐ Abscess (site) ________	☐ Gastric	☐ Throat swab
☐ Blood	☐ Lesion (site)________	☐ Tissue (site) ___________
☐ Bone marrow	☐ Lymph node (site) ______	☐ Urethral
☐ Bronchial washings	☐ Nasopharyngeal	☐ Urine
☐ Cervical	☐ Plasma	☐ Vaginal
☐ CSF	☐ Rectal swab	☐ Wound (site) ___________
☐ Endocervical	☐ Serum	☐ Swab Site:___________
☐ Eye	☐ Sputum: Induced	_____________
☐ Feces/stool	☐ Sputum: Natural	☐ Other: _______________

Section 5. ORDERING PHYSICIAN INFORMATION

Ordering Physician's NPI Number	Ordering Physician's Name

Section 6. PAYOR SOURCE

☒ CDC Special Project (14)

Comments/Notes:
Reflex testing will be performed when necessary

Section 7. COLLECTION SITE INFORMATION

CLIA#

Collection Site Name

Collection Site Infection Control Contact Name

Collection Site Infection Control Contact Phone Number

Collection Site Sample Number	Zip Code

Section 4. TEST REQUESTED -- (**REQUIRED)

Is the specimen an **isolate?**** ☐ YES ☐ NO

If the specimen is an **isolate,** print the name of the organism: ____

If specimen is an **isolate,** check the box for **One** of the test options below

☐ Carbapenem Resistant Panel (**CRAB:** Carbapenem Resistant Acinetobacter, **CRE:** Carbapenem Resistant Enterobacteriaceae, **CRPA:** Carbapenem Resistant Pseudomonas Aeruginosa)

☐ ESBL (Extended-Spectrum BETA-Lactamase) Panel – Must be susceptible to all carbapenems tested and resistant to third generation cephalosporins.

☐ Candida identification by MALDI (Candida susceptibilities may be performed depending on the organism).

***Attach copy of previous lab results**

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☐ Colonization Testing Only

Print the name of the suspected organism (i.e. CRE, CRPA, CRAB, Candida auris, 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. Visit our web site at http://www.dshs.texas.gov/lab/.

FOR TEXAS DSHS LABORATORY USE ONLY:

Specimen Received: ☐ Room Temp. ☐ Cold ☐ Frozen
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