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

South Texas Laboratory
CAP #2148801 CLIA #45D0503753
Phone: (956) 364-8746 **Fax:** (956) 412-8794

Remember 1-1

1 FORM = 1 SAMPLE
Please complete a separate form for each specimen submitted

SPECIMEN BARCODE / Address-O-Graph

This Space for DSHS Laboratory Use Only

F40-B Specimen Submission Form - South Texas Laboratory

SECTION 1. SUBMITTER

** REQUIRED

Submitter/TPI Number **	Submitter Name**		
NPI Number **	Address **		
City **	State **	Zip Code **	
Phone Number **	Fax **	Contact Name and/or Email Address	

SECTION 2. PATIENT

NOTE: **Patient name** on specimen MUST match name on this form **exactly**.
Name mismatches will be rejected. *e.g., Partial name on specimen label but full name is provided on form.*
Specimen **container must have two (2) unique identifiers** that match this form exactly. *e.g., DOB, Unique ID#.*

** REQUIRED

Last Name **	First Name **	MI	
Address **		Phone Number	
City **	State **	Zip Code **	Pregnant? ☐ Yes ☐ No ☐ Unknown
DOB *(mm/dd/yyyy)* **	Sex**	Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown	

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

Diagnosis / Symptoms Θ	Risk	☐ Inpatient ☐ Outpatient
Date of Onset Θ	☐ Outbreak Association Θ ☐ Surveillance Θ	Country of Origin / Bi-National ID Θ
ICD Diagnosis Code † (1)	ICD Diagnosis Code † (2)	ICD Diagnosis Code † (3)

Θ Indicates fields of epidemiological interest. If sample/test is related to an epidemiology investigation, complete relevant fields.

† Indicate the diagnosis code that would help in processing, identifying, and billing of this specimen.

SECTION 3. SPECIMEN

NOTE: If the 'Date of Collection' field is not completed, the specimen will be rejected.

** REQUIRED

Date of Collection *(mm/dd/yyyy)* **	Time of Collection ** ☐ AM ☐ PM	Collected by:
Unique Identification Number ** *e.g., MRN / Alien # / Accession ID*	Comments or Additional ID: *e.g., CDC ID, Previous DSHS Specimen Lab Number*	

Specimen Source or Type (Select One Only) **

☐ Abdominal Fluid	☐ Eye Swab	☐ Nasopharyngeal Swab	☐ Tissue (specify site)
☐ Abscess (specify site)	☐ Feces / stool	☐ Plasma	☐ Tracheal Aspirate
☐ Blood	☐ Gastric	☐ Rectal Swab	☐ Urethral Swab
☐ Bone Marrow	☐ Lesion (specify site)	☐ Serum	☐ Urine
☐ Bronchial washings	☐ Liver Aspirate	☐ Sputum: Induced	☐ Vaginal Swab
☐ Cervical Swab	☐ Lymph node (site) (specify site)	☐ Sputum: Natural	☐ Wound (specify site)
☐ CSF		☐ Throat Swab	☐ Other:
☐ Endocervical Swab			

SECTION 4. MYCOBACTERIOLOGY

☐ AFB Culture
☐ AFB Smear Only
☐ AFB Concentration
☐ Conventional Susceptibility (each drug)
☐ Nucleic Acid Amplification (NAAT) for *M.tuberculosis* and Rifampin Resistance Detection (Respiratory Diagnostic Specimen Only)
☐ MGIT Susceptibility (each drug)
☐ MGIT Susceptibility (each drug) PZA

SECTION 5. ORDERING PHYSICIAN

** REQUIRED

Physician's NPI Number**	Physician's Name**

SECTION 6. PAYOR SOURCE

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.
5. **Check only one box below** to indicate whether we should bill the submitter, Medicaid, Medicare, or DSHS Program.

** REQUIRED

☐ Submitter (3)	☐ TB Elimination (1619)
☐ HIV/STD (1608)	☐ Other:
☐ OPC (5507)	
☐ Medicaid (2)	☐ Medicare (8)
Medicaid/Medicare #:	

Notes/Comments:

SECTION 7. SEROLOGY

☐ Syphilis (RPR) screen (qualitative)
☐ Syphilis (RPR) screen (quantitative)
☐ Syphilis TP-PA ●
● Justification: ☐ Contact ☐ Exposure ☐ Follow-up ☐ Confirmation/ Conflicting Results ☐ Other:

▲ **REQUIRED for Section 7 – If specimen is stored in an appliance prior to shipping, Indicate REMOVAL from:**
☐ FREEZER ☐ REFRIGERATOR

DATE (mm/dd/yyyy)	**TIME** (hh:mm) ☐ AM ☐ PM

NOTES: ● = Justification is required if TP-PA is requested regardless of RPR results.
▲= Document **time & date** specimens were **removed from FREEZER / REFRIGERATOR** in the lower right-hand box.
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. Serology) requires a separate form and specimen. Please see the form's instructions for details on how to complete this form.

LABORATORY TEST RESULTS SECTION - *FOR LABORATORY USE ONLY*

TEST	NONREACTIVE	REACTIVE	TITER
RPR			
TP-PA			

☐ Results for the TP-PA are inconclusive due to nonspecific hemagglutination in serum control

UNSATISFACTORY:

☐ Broken in Mail ☐ Leaked in Transit ☐ No Specimen Received ☐ Thyroid
☐ Hemolyzed ☐ Name Discrepancy ☐ Quantity Not Sufficient ☐ Please Resubmit:

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