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

CAP# 3024401 CLIA #45D0660644

Questions? LabInfo@dshs.texas.gov

Specimen Acquisition: (512) 776-7598

Remember 1-1

1 FORM = 1 SAMPLE

Please complete a separate form for each specimen submitted

SPECIMEN BARCODE
This Space for DSHS Laboratory Use Only

G-1B Specimen Submission Form

Submission Form Guidance

- All dates must be entered in **mm/dd/yyyy format**.
- Please complete a separate form *for each* specimen submitted.
- Details of test and specimen requirements can be found in the Laboratory Testing Services Manual. Visit our website at https://www.dshs.texas.gov/lab

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

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 **
DOB *(mm/dd/yyyy)* **	Sex**	Pregnant? ☐ Yes ☐ No ☐ Unknown

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

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

Diagnosis / Symptoms Θ	Risk	☐ Inpatient ☐ Outpatient
Date of Onset Θ	☐ Outbreak Association Θ ☐ Surveillance Θ	Country of Origin / Bi-National ID
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.

† Indicates 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., DOC ID, Previous DSHS Specimen Lab Number*	

Specimen Source or Type (Select One Only) **

☐ Blood: Capillary ☐ Blood: Venous ☐ Other: _____

☐ Blood: Filter Paper ☐ Serum

SECTION 4. HEMOGLOBIN AND LEAD (HL)

☐ **Hemoglobin**

☐ **Lead**

If this is a follow-up due to a previous elevated lead result, mark "Yes" below and provide previous DSHS specimen lab number in Section 3.

☐ Yes

SECTION 5. HEMOGLOBIN TYPE

☐ **Hemoglobinopathy**

(Accepted on Sna[illegible] Card Only)

SECTION 6. PKU DIETARY MONITORING

PKU Dietary Monitoring is a stand-alone test, not associated with the Newborn Screening Panel.

☐ **Phenylalanine/Tyrosine**

SECTION 7. CHEMISTRIES

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

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

☐ **Cholesterol ▲**

☐ **High-density lipoprotein (HDL) ▲**

☐ **Lipid Panel ▲**

(Includes cholesterol, triglycerides, HDL, and calculated low-density lipoprotein (LDL))

Diabetes:

☐ **Glucose, Random ▲**

☐ **Glucose, Fasting ▲**

____ ____. *Hrs. Time since last meal*

SECTION 8. ORDERING PHYSICIAN

**** REQUIRED**

Physician's NPI Number**	Physician Name**

SECTION 9. 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. 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.

** REQUIRED

☐ Medicaid (2) ☐ Medicare (8)

Medicaid/Medicare #: _____

☐ Submitter (3)	☐ Private Insurance* (4)
☐ BIDS (1720)	☐ Other: _____
☐ TB Elimination (1619)	

HMO / Managed Care / Insurance Company Name *		
Address*		
City *	State *	Zip Code *
Responsible Party / Subscriber *		
Insurance Phone Number *	Insurance ID Number *	
Group Name	Group Number	

Signature of Patient or Responsible Party

"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, Public Health Laboratory Division."

Signature *	Date *

SECTION 10. DNA ANALYSIS

☐ **Galactosemia:** Common Mutation Panel

☐ **Cystic Fibrosis:** Mutation Panel

☐ **MCAD:** Mutation Panel

☐ **VLCAD:** Gene Sequencing

☐ **X- ALD:** Targeted Sequencing

☐ **X- ALD:** Full Gene Sequencing

Hemoglobin DNA Test:

☐ Hb S, C, E, D, or O-Arab

☐ Common Beta-Thalassemia Mutation

☐ Beta-Globin Gene Sequencing

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

Indicate REMOVAL from:

☐ FREEZER ☐ REFRIGERATOR

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

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