

**Texas Department of State Health Services** 

CLIA #45D0660644

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

CAP# 3024401 Questions? LabInfo@dshs.texas.gov Specimen Acquisition: (512) 776-7598

## **G-1B Specimen Submission Form** All dates must be entered in mm/dd/yyyy format.

• Please complete a separate form <i>for each</i> specimen submitted. • Details of test and specimen requirements can be found in the Laboratory Testing Services Manual. Visit our website at <a href="https://www.dshs.texas.gov">https://www.dshs.texas.gov</a> ClinicalChemistry@dshs.texas.gov															
SECTION 1. SUBMITTER										SECTION 8. ORDERING PHYSICIAN					
	Submitter/TPI Number ** Submitter Name*									** REQUIRED					
** REQUIRED	NDI Norskan *	A -l -l	Add **							cian's NPI Number**	Physic	Physician's Name**			
	NPI Number ** Address **										SECTION 9. PAYOR SOURCE				
	City ** State ** Zip Code **									Reflex testing will be performed when necessary and the appropriate party will be billed.					
*	Phone Number ** Fax **					Contact Name and/or Email Address				2. If the	ne patient does not meet protest requested and no third submitter will be billed.	gram eligibi			
	SECTION 2. PATIENT										Medicare generally does not pay for screening tests-please refer to applicable Third-party payor guidelines for instructions				
NOTE	: Patient name	on specimen I	MUST mat	regarding covered tests, benefit limitations, medical necessity determinations and Advanced Beneficiary Notice (ABN)											
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#.										requirements.  4. If Medicaid or Medicare is indicated, the Medicaid/Medicare					
Q	Last Name **  First Name **  MI									number is required. Please write it in the space provided.					
	Address **					Phone Number				It private insurance is indicated, the required billing information below is designated with an asterisk (*).					
E E	1 Hote Number									Check only one box below to indicate whether we should bill the submitter, Medicaid, Medicare, private insurance, or DSHS					
** REQUIRED	City ** State			State **	** Zip Code **			Pregnant? ☐ Yes ☐ No ☐ Unknown		Program.			П.М. (Голого (О)		
	DOB (mm/dd/yyyy) ** Se			Sex**				☐ Hispanic ☐ U	Inknown	Ë	☐ Medicaid (2)  Medic	Medicaid (2) ☐ Medicare (8)  Medicaid/Medicare #:			
	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						Ethnicity:	□ Non-Hispanic		REQUIRED	□ Submitter (3)	☐ Pri	vate Insurance* (4)		
Race	☐ White ☐ American ☐ American ☐ Nativ			erican Indian / Native Alask ve Hawaijan / Pacific Islan				ner epidemiological inte	rest. If		☐ BIDS (1720) ☐ TB Elimination (16	Ot Ot	her:		
Diagn	osis / Symptom	sΘ	F	Risk			☐ Inpatient		tigation,	*	L 18 Ellillillation (10	9)			
Date	□ Outpatient complete relevant fields.  Date of Onset Θ □ Outbreak Association Θ □ Country of Origin / Bi-National □ Θ □ Indicate the diagnosis code										HMO / Managed Care / Insurance Company Name *				
ICD F	□ Surveillance Θ that would help in processing,										Address*  City * State * Zip Code *				
IOD L	ICD Diagnosis Code † (1) ICD Diagnosis Code † (2) ICD Diagnosis Code † (3) ICD Diagnosis Code † (4) ICD Diagnosis Code † (5) ICD Diagnosis Code † (6) ICD Diagnosis Code † (7) ICD Diagnosis Code † (8) ICD Diagnosis Code †														
SECTION 3. SPECIMEN										Responsible Party / Subscriber *					
NOTE	E: If the 'Date of Collection' field is not completed, the specimen will be rejected.  Date of Collection (mm/dd/yyyy) ** Time of Collection ** Collected by:									rtespt	onsible Faity / Subscriber				
** REQUIRED	Time of Colle				Jonecho	Z AM				Insurance Phone Number *		Insurance ID Number *			
	Unique Identification Number **					Comments or Additional ID:					o Name	Group	Group Number		
	e.g., MRN / Alien # / Accession ID									Signature of Patient or			Responsible Party		
	Specimen Source or Type (Select One Only) **									"I hereby authorize the release of information related to the services described here and hereby assign any benefits to which I					
*	☐ Blood: Capillary ☐ Blood: Venous ☐ Other: ☐ Serum									am	entitled to the Texas Depa Public Health La				
										Signa	ture *	Date *			
SECTION 4. HEMOGLOBIN AND LEAD (HL)  If this is a follow-up due to a previous elevated lead result, mark  SECTION 10. DNA ANALYSIS													LYSIS		
□ Hemoglobin □ Lead □ Yes □ Hemoglobin □ Yes □ Yes □ Hemoglobin □ Yes □ Yes □ Hemoglobin □ Yes										☐ Galactosemia: Common Mutation Panel					
										☐ Cystic Fibrosis: Mutation Panel☐ MCAD: Mutation Panel☐					
SECTION 5. HEMOGLOBIN TYPE SECTION 6. PKU DIETARY MONITORING									RING	□ VLCAD: Gene Sequencing					
PKU Dietary Monitoring is a stand-alone test, not associate with the Newborn Screening Panel.							ssociated	☐ X -ALD: Targeted Sequencing ☐ X-ALD: Full Gene Sequencing							
(Accepted on Snap-Apart Card Only)									☐ Hemoglobin DNA Test:						
			SE	ECTION		Hb S, C, E, D, or O-Arab Common Beta-Thalassemia Mutation									
<u>NOTE</u> : 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 /											Beta-Globin Gene Sequencing				
	olesterol ▲	sppa.100 pir			in the l	box to the b	ottom right.		,	_	EQUIRED for cold	•	ts, if stored in		
Diabetes:  ☐ High-density lipoprotein (HDL) ▲ ☐ Glucose, Random ▲									an appliance prior to shipping. Indicate REMOVAL from:						
☐ Lipid Panel ▲ ☐ Glucose, Fasting ▲  (Includes cholesterol, triglycerides, HDL, and low-								/a-4 1	DATE	☐ FREEZER ☐ E (mm/dd/yyyy)	REFRIG				
density lipoprotein (LDL))  Hrs. Time since last meal											,	´ □ AM □ PM			

FOR DSHS LABORATORY USE ONLY:

☐ Room Temp.

Specimen Received:

☐ Frozen

□ Cold