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

Specimen Acquisition: (512) 776-7598

G-1B Specimen Submission Form (Jan 2022)

CAP# 3024401 CLIA #45D0660644

www.dshs.texas.gov/lab

******For DSHS Use Only*****

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** on specimen **MUST** match name on this form & Medicaid/Medicare and Insurance 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

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 ** (REQUIRED)

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)

☐ Inpatient ☐ Outpatient ☐ Outbreak association: ☐ Surveillance

Date of Onset (mm/dd/yyyy)

Diagnosis / Symptoms

Risk

Section 3. SPECIMEN TYPE

☐ Blood: Capillary ☐ Blood: Filter Paper ☐ Blood: Venous ☐ Serum ☐ Other:

Section 4. Hemoglobin and Lead (HL)

☐ **Hemoglobin**

☐ **Lead**

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

☐ Yes

Section 5. HEMOGLOBIN TYPE

☐ **Hemoglobin electrophoresis**

(Accepted on Snap-Apart Card only)

Section 6. PKY DIETARY MONITORING

☐ **Phenylalanine/Tyrosine**

(Does not include full NBS panel)

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 below.

☐ **Creatinine ▲**

☐ **Cholesterol ▲**

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

☐ **Lipid panel ▲**

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

Diabetes:

☐ **Glucose, Random ▲**

☐ **Glucose, Fasting ▲**

__ __.__ **hrs.** Time since last meal

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 and specimen requirements can be found in the Laboratory Testing Services Manual. Visit our web site at http://www.dshs.texas.gov/lab/ .

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

Section 8. ORDERING PHYSICIAN INFORMATION (** REQUIRED)

Ordering Physician's NPI Number ** | **Ordering Physician's Name ****

Section 9. 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. 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. **Write** it in the space provided below.
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.

☐ Medicaid (2) ☐ Medicare (8)

Medicaid/Medicare #:

☐ Submitter (3) ☐ BIDS (1720) ☐ HIV / STD (1608) ☐ TB Elimination (1619)

☐ Private Insurance (4) ☐ Title XX (13) ☐ Other: _____

HMO / Managed Care / Insurance Company Name *

Address *

City * | State * | Zip Code *

Responsible Party (Last Name, First Name) *

Insurance Phone Number * | Responsible Party's Insurance ID Number *

Group Name | Group Number

"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, Laboratory Services Section."
Signature of patient or responsible party.

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 (hr min) ☐ AM ☐ PM

FOR LABORATORY USE ONLY

Comments:

Specimen Received: ☐ **Room Temp.** ☐ **Cold** ☐ **Frozen**