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-2E Specimen Submission Form

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

## SECTION 5. ORDERING PHYSICIAN

| Physician's NPI Number | Physician's Name |
|---|---|

## SECTION 6. PAYOR SOURCE

☒ CDC Special Project (14)

Comments/Notes:
Reflex testing will be performed when necessary

## SECTION 7. COLLECTION SITE

**REQUIRED

| Collection Site Name** | |
|---|---|
| Collection Site Sample Number** | Zip Code** |
| Collection Site Infection Control Contact Name | |
| Collection Site Infection Control Contact Phone Number | |
| CLIA# | |

## SECTION 4. TEST REQUEST – Select one box (isolate or colonization) and one organism test

### BOX 1

☐ **Isolate Testing**

****REQUIRED:** Attach previous lab results or write previous results on back of form

Print the name of the organism:

Select **ONE** isolate test below:

- ☐ *Candida* identification by MALDI (*Candida* susceptibility may be performed)
- ☐ CRAB: Carbapenem Resistant *Acinetobacter*
- ☐ CRE: Carbapenem Resistant Enterobacterales
- ☐ CRPA: Carbapenem Resistant *Pseudomonas aeruginosa*

### BOX 2

☐ **Colonization Screening ONLY**

**NOTE:** Only performed with approval from coordinating regional epidemiologist

Select **ONE** screening organism below:

- ☐ *Candida auris*
- ☐ CRAB: Carbapenem Resistant *Acinetobacter*
- ☐ CRE: Carbapenem Resistant Enterobacterales
- ☐ CRPA: Carbapenem Resistant *Pseudomonas aeruginosa*
- ☐ Other: _____

***FOR DSHS LABORATORY USE ONLY:***

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