



TEXAS Health and Human Services

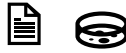
Texas Department of State Health Services

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-2V 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.
Specimen container must have two (2) unique identifiers that match this form exactly.
Last Name \*\*, First Name \*\*, MI, Address \*\*, Phone Number, City \*\*, State \*\*, Zip Code \*\*, Pregnant? Yes No Unknown, Sex \*\*, Ethnicity: Hispanic, Non-Hispanic, Unknown, Race: White, Black or African American, American Indian / Native Alaskan, Native Hawaiian / Pacific Islander, Asian, Other, Diagnosis / Symptoms, Risk, Date of Onset, Outbreak Association, Surveillance, Country of Origin / Bi-National ID, ICD Diagnosis Code

SECTION 3. SPECIMEN
NOTE: If the 'Date of Collection' field is not completed, the specimen will be rejected
Date of Collection (mm/dd/yyyy) \*\*, Time of Collection \*\*, AM PM, Collected by:
Unique Identification Number \*\*, Comments or Additional ID:
Specimen Source or Type (Select One Only)
Blood, Bronchoalveolar Lavage, Buccal swab, CSF, Feces/stool, Nasopharyngeal swab, Nasal Swab, Serum: Acute Date, Conv. Date, Sputum: Induced, Natural, Throat Swab, Urine, Other

SECTION 4. VIROLOGY
Influenza surveillance (Influenza PCR), Vaccine Received: Yes No, Date Vaccine Received: , Travel History (if known):
Measles PCR, Vaccine Received: Yes No, Date Vaccine Received: , Travel History (if known):
Mumps PCR, Vaccine Received: Yes No, Date Vaccine Received: , Travel History (if known):
COVID-19 (SARS-CoV-2) PCR, Vaccine Received: Yes No, Date Vaccine Received: , Travel History (if known):
NOTE: By checking the Influenza Surveillance or COVID-19 PCR test request box, submitters authorize DSHS to test for Influenza and/or COVID as resources allow.

FOR DSHS USE ONLY
DSHS Lab Staff Notes:
FOR DSHS LABORATORY USE ONLY
Specimen Received: Room Temp. Cold Frozen

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. 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), BIDS (1720), IDEAS (1610), Immunizations (1609), Private Insurance\* (4), Zoonosis (1620), Other:
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 7. ARBOVIRUSES / ZOONOTIC
Zika, Dengue, and/or Chikungunya
Arbovirus IgM (West Nile, St. Louis Encephalitis)
NOTE: DSHS may test for Zika, Dengue, Chikungunya, West Nile (WN), St. Louis Encephalitis (SLE) and/or other emerging arboviruses, as needed. Serology, PCR, or both will be performed at DSHS and the testing methodology and specific viruses analyzed will be based on clinical symptoms and current epidemiological testing criteria. Testing may initially be performed to identify a specific suspected virus or viruses. Reflex testing may be ordered based on initial results and/or approval of additional testing. In some instances, specimens may also be forwarded to CDC for further testing.

REQUIRED for Section 7, Arbovirus IgM Testing - If specimen is stored in an appliance prior to shipping, Indicate REMOVAL from:
FREEZER, REFRIGERATOR
DATE (mm/dd/yyyy), TIME (hh:mm) AM PM

FOR DSHS USE ONLY
Testing Criteria: Met Not Met
PCR: C, D, Z, Serology: C, D, Z, Initials, Date
Other: