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. *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

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.

Diagnosis / Symptoms Θ	Risk	**REQUIRED**** ☐ 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)

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)

☐ Blood
☐ Bronchoalveolar Lavage
☐ Buccal swab
☐ CSF
☐ Feces/stool
☐ Nasopharyngeal swab
☐ Nasal Swab
☐ Serum:
Acute Date: (mm/dd/yyyy) ____/____/____
Conv. Date: (mm/dd/yyyy) ____/____/____
☐ Sputum: Induced
☐ Sputum: Natural
☐ Throat Swab
☐ Urine
☐ Other: _____
NOTE: *DO NOT FREEZE Serum Separator Tube (SST) collectors (i.e. Gold Top tubes)*

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): _____

☐ Other: _____

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)	☐ Private Insurance* (4)
☐ BIDS (1720)	☐ Zoonosis (1620)
☐ IDEAS (1610)	☐ Other:
☐ Immunizations (1609)	

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) ▲
☐ Other: _____

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:	Serology:	Initials	Date
☐ C ☐ D ☐ Z	☐ C ☐ D ☐ Z		
☐ Other: _____			