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-MYCO 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 **
DOB *(mm/dd/yyyy)* **	Sex**	Pregnant? ☐ Yes ☐ No ☐ Unknown

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Race: ☐ White ☐ American Indian / Native Alaskan ☐ Asian ☐ Black or African American ☐ Native Hawaiian / Pacific Islander ☐ 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 is related to an epidemiological investigation, complete relevant fields.

† Indicate the diagnosis code that will 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 or previous DSHS Specimen Lab Number*	

Specimen Source or Type (Select One Only) **

- ☐ Abdominal Fluid
- ☐ Abscess (specify site)
- ☐ Aspirate (specify site)
- ☐ BAL
- ☐ Biopsy
- ☐ Bronchial washings
- ☐ Cervical Swab
- ☐ CSF
- ☐ Ear Swab
- ☐ Feces/stool
- ☐ Fine Needle Aspirate (specify site)
- ☐ Gastric (Aspirate)
- ☐ Gastric Contents
- ☐ Lesion (specify site)
- ☐ Lymph node (specify site)
- ☐ Pleural fluid/PLF
- ☐ Sputum: Induced
- ☐ Sputum: Natural
- ☐ Thoracentesis fluid
- ☐ Tissue (specify site)
- ☐ Vaginal Swab
- ☐ Wound (specify site)
- ☐ Other:

SECTION 4. CLINICAL SPECIMEN

FOR RAW UNPROCESSED SPECIMENS:
- ☐ AFB Smear Only (for release from isolation)
- ☐ AFB Smear and Culture
- ☐ AFB Smear, Culture and Nucleic Acid Amplification (NAAT) for *M. tuberculosis* and Rifampin Resistance Detection (Respiratory Diagnostic Specimens Only)

FOR PROCESSED RESPIRATORY SEDIMENTS ONLY:
- ☐ Nucleic Acid Amplification (NAAT) for *M. tuberculosis* and Rifampin Resistance Detection (NAAT ONLY – NO CULTURE PERFORMED)

Please provide AFB smear result(s) for this processed sediment: _____ AFB/field

SECTION 5. REFERRED PURE CULTURE

- ☐ Referred AFB Isolate Identification
- ☐ MTB Genotyping Only/for Compliance
- ☐ Fungal Isolate Identification
- ☐ Actinomycete, Aerobic, Identification

Comments/Notes:

SECTION 6. ORDERING PHYSICIAN

** REQUIRED

Physician's NPI Number**	Physician's Name**

SECTION 7. 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)	☐ IDEAS (1610)
☐ TB Elimination (1619)	☐ 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 8. SUSCEPTIBILITY TESTING

Is MDR *M. tuberculosis* suspected?
☐ Yes ☐ No

Note: Drug susceptibility tests are performed automatically on patient's initial *M. tuberculosis* isolate.

☐ **MTB PZA Susceptibility Test Only**

☐ **MTB Primary Drug Susceptibility Panel Plus Ofloxacin:**
- ☐ Ethambutol
- ☐ Isoniazid
- ☐ Pyrazinamide (PZA)
- ☐ Rifampin
- ☐ Ofloxacin

☐ **MTB Agar Susceptibility Panel:**
- ☐ Capreomycin
- ☐ Ethambutol
- ☐ Ethionamide
- ☐ Isoniazid
- ☐ Kanamycin
- ☐ Ofloxacin
- ☐ Rifabutin
- ☐ Rifampin
- ☐ Streptomycin

***M. kansasii* Susceptibility Test:**
☐ Agar, Rifampin

FOR DSHS LABORATORY USE ONLY: **Specimen Received:** ☐ Room Temp. ☐ Cold ☐ Frozen