

Texas Department of State Health Services

CAP# 3024401 CLIA #45D0660644 Questions? <u>LabInfo@dshs.texas.gov</u> Specimen Acquisition: (512) 776-7598



SPECIMEN BARCODE

This Space for DSHS Laboratory Use Only

G-THS Specimen Submission Form

FOR TEXAS HEALTH STEPS SPECIMENS ONLY!!!

**All dates must be entired in mindfully yr format. **Details of beta and specimen requirements can be found in the Laboratory Testing **Private Complete Section 1. Substitute **SECTION 1. SUBMITTER **SECTION 1. SUBMITTER **SECTION 1. SUBMITTER **SECTION 1. SUBMITTER **SECTION 3. SUBMITTER **SECTION 3. SUBMITTER **SECTION 4. SUBMITTER **SECTION 4. SUBMITTER **SECTION 5. SUBMITTER **SECTION 6. SUBMITTER **SECTION 6. SUBMITTER **SECTION 7. SUBMITTER **SECTION 7. SUBMITTER **SECTION 7. SUBMITTER **SECTION 8. SUBMIT	IS THIS SUBMISSION PART OF THE THSTEPS MEDICAL CHECKUP OR FOLLOW-UP VISIT? Yes No												
Submitter TP Number ** NP1 Number ** Address ** Phone Number ** SECTION 2 PATIENT ** NOTE: Fatter them on spectrum shugh IT match mans on this form oxacity. Same interaction and the street of the spectrum oxacity and the spectrum shugh It match mans on the form oxacity. Section 2 PATIENT NOTE: Fatter them on spectrum shugh IT match mans on this form oxacity. Section 3 Patient share in spectrum shugh IT match mans on this form oxacity. Section 4 Patient share in spectrum shugh IT match mans on this form oxacity. Section 5 Patient share in share the share in spectrum shugh It match mans on the form oxacity. Section 6 Patient share in spectrum shugh IT match mans on the form oxacity. Share instrumed the will be rejected 4. g. Pentil mans on pits from oxacity. Share instrumed the will be rejected 4. g. Pentil mans on pits from oxacity. Share instrumed the will be rejected 4. g. Pentil mans on pits from oxacity. Share instrumed the will be rejected 4. g. Pentil mans on pits from oxacity. Share instrumed the will be rejected 4. g. Pentil mans on pits from oxacity. Share instrumed the will be rejected 4. g. Pentil mans on pits from oxacity. Share instrumed the will be rejected 4. g. Pentil mans on pits from oxacity. Share instrumed the will be rejected 4. g. Pentil share on paperone share instrumed the form oxacity. Share instrumed the will be rejected 4. g. Pentil share on paperone share instrumed the share of provided or for share of the share of	• Please complete a separate form for each specimen submitted. • Details of test and specimen requirements can be found in the Laboratory Testing • Please complete a separate form for each specimen submitted. • Details of test and specimen requirements can be found in the Laboratory Testing												
Population Pop	SECTION 1. SUBMITTER						SECTION 4. ORDERING PHYSICIAN						
Note Price		Submitter/TPI Number ** Submitter Name**											
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SECTION 2. PATIENT NOTE: Patient name on specimen MUST match name on this form exactly. Name mismatches will be rejected. e.g., Parient name on specimen falled but full name is provided on form Specimen container must have two (2) unique identifiers that match this form exactly. Lusi Name " Lusi Name " State " Zip Code " Pignant? Pignant		Phone Number **	Fax **	Contact Name and/or Email Address			the test requested and no third-party payor will cover the testing,						
Note: If the Date of Collection finding and contribution finding and the specimen Numbers will be rejected. Proceeding and the specimen shade and the specimen shade but full name is provided on form exactly.	SECTION 2. PATIENT							If the Medicaid number is not provided or is inaccurate, the					
Specimen container must have two (2) unique Identifiers that match this form exactly. e.g., DOB, Unique (0) Lest Name ** First Name ** First Name ** Phone Number	NOTE								4 Please write the Medicaid number in the space provided below.				
City ** State ** Zip Code ** Preparat? Sec No Unknown SecTION 6. HEMOGLOBIN AND LEAD (HL)	=	Specimen container must have two (2) unique identifiers that match this form exactly. e.g., DOB, Unique ID#.							및 ☑ THSteps (1613)				
City ** State ** Zip Code ** Preparat? Sec No Unknown SecTION 6. HEMOGLOBIN AND LEAD (HL)		Last Name **				MI	Ingi	Medicaid	#: **				
DOB (mmotolyyyyy) ** Sex* Ethylethy: Stapsine Unknown Race: White Management M	REQUIRE	Address **			Phone Number	Phone Number							
Comments		City **	State ** Zip (Code **		nknown	SECTION 6. HEMOGLOBIN AND LEA			D (HL)			
Black or African American Native Hawaiian / Pacific Islander Others	*		OOB (mm/dd/yyyy) ** Sex** Ethnicity: Hispanic U Non-Hispanic				☐ Lead ☐ Hemoglobin a previous abnormal/elevated lead result. Provide previous DSHS specimen lab						
Date of Onset 0	Race: Black or African American Native Hawaiian / Pacific Islander Other epidemiological interest. If												
Date of Onset Ons	biagnosis / Symptoms 9 Nisk Engatient epidemiology investigation.						_						
CD Diagnosis Code † (1) ICD Diagnosis Code † (2) ICD Diagnosis Code † (3) Identifying, and billing of this specimen.	Date of Onset Θ □ Outbreak Association Θ □ Country of Origin / Bi-National ID Θ □ Indicate the diagnosis code that would help in processing							II					
SECTION 3. SPECIMEN NOTE: If the 'Date of Collection' field is not completed, the specimen will be rejected.	ICD	Diagnosis Code † (1) ICD Dia	NOTE: DO NOT FREEZE Serum Separator Tube (SST)										
NOTE: If the 'Date of Collection' field is not completed the specimen will be rejected. Date of Collection (mm/ddyyy)	SECTION 3. SPECIMEN							·					
Date of Collection (mm/ad/yyyy)	NOTE: If the 'Date of Collection' field is not completed, the specimen will be rejected.							_					
Unique Identification Number* e.g., MRN / Alien # / Accession ID Specimen Source or Type (Select One Only) Blood: Capillary Blood: Venous For DSHS LABORATORY USE ONLY Comments: Unique Identification Number* Includes cholesterol, triglycerides, HDL, and low-density lipoprotein (LDL) Glucose, Random {Diabetes}}		□ AM											
Specimen Source or Type (Select One Only) Blood: Capillary Blood: Venous Plasma Specimen Swab Serum Other: Blood: Serum Other: Specimen Notes/Comments: Specimen Notes/Comments: Specimen Notes/Comments: Specimen Source or Type (Select One Only) Glucose, Random {Diabetes} ▲ Glucose, Fasting {Diabetes} ▲ NOTE: DO NOT FREEZE Serum Separator Tube (SST) collectors (i.e. Gold Top tubes) A REQUIRED for cold shipments, if stored in an appliance prior to shipping. Indicate REMOVAL from: FREEZER REFRIGERATOR DATE (mm/dd/yyyy) TIME (nh:mm) PM Comments:													
Specimen Source or Type (Select One Only) Blood: Capillary Blood: Venous Blood: Capillary Blood: Capillary Blood: Venous Blood: Capillary Blood: Venous Blood: Capillary Blood: Capi	ED	e.g., MRN / Alien # / Accession ID					lipoprotein (LDL)						
Plasma Throat Swab Vaginal Swab Other: A REQUIRED for cold shipments, if stored in an appliance prior to shipping. Indicate REMOVAL from: FREEZER REFRIGERATOR	REQUI	Specimen Source or Type (Select One Only)					_ _ _						
Specimen Notes/Comments: Serum		☐ Blood: Capillary ☐ Rectal Swab ☐ Urine											
Specimen Notes/Comments: Specimen Notes/Comments:			· · · · · · · · · · · · · · · · · · ·				. ,						
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FOR DSHS LABORATORY USE ONLY Comments:	Spe	cimen Notes/Comments:						☐ FREEZE	ER [REFRIGERAT	OR		
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Comments:													
				FOR L	SHS LABORATORY US	SE ONLY							
	Com	nments:											
Specimen Received: ☐ Room Temp. ☐ Cold ☐ Frozen													