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-THSTEPS Specimen Submission Form

FOR TEXAS HEALTH STEPS SPECIMENS ONLY!!!

IS THIS SUBMISSION PART OF THE THSTEPS MEDICAL CHECKUP OR FOLLOW-UP VISIT? ☐ Yes ☐ No

Submission Form Guidance

- All dates must be entered in **mm/dd/yyyy format.**
- Please complete a separate form *for each* specimen submitted.
- Details of test and specimen requirements can be found in the Laboratory Testing Services Manual. Visit our website at https://www.dshs.texas.gov/lab

For assistance or questions, email ClinicalChemistry@dshs.texas.gov

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 **	
Address **		Phone Number
City **	State **	Zip Code **
DOB *(mm/dd/yyyy)* **	Sex**	Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Pregnant? ☐ Yes ☐ No ☐ Unknown

Race: ☐ White ☐ American Indian / Native Alaskan ☐ Asian ☐ Black or African American ☐ Native Hawaiian / Pacific Islander

Diagnosis / Symptoms Θ	Risk	☐ Inpatient ☐ Outpatient
Date of Onset Θ	☐ Outbreak Association Θ ☐ Surveillance Θ	Country of Origin / Additional ID
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 #*	Comments or Additional ID: *e.g., CDC ID, Previous DSHS Specimen Lab Number*	

Specimen Source or Type (Select One Only)

☐ Blood: Capillary	☐ Rectal Swab	☐ Urine
☐ Blood: Venous	☐ Throat Swab	☐ Vaginal Swab
☐ Endocervical Swab	☐ Serum	☐ Other:
☐ Plasma	☐ Urethral Swab	

Specimen Notes/Comments:

SECTION 4. ORDERING PHYSICIAN

** REQUIRED

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

SECTION 5. 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. If the Medicaid number is not provided or is inaccurate, the submitter will be billed.
4. Please write the Medicaid number in the space provided below.

** REQUIRED

☒ **THSteps** (1613)

Medicaid #: **

_____

SECTION 6. HEMOGLOBIN AND LEAD (HL)

☐ Hemoglobin
☐ Lead

☐ Check this box if this a follow-up test for a previous abnormal/elevated lead result. Provide previous DSHS specimen lab number in Section 2.

SECTION 7. STI

☐ Gonorrhea/Chlamydia (GC/CT), Amplified RNA Probe
☐ HIV▲
☐ Syphilis▲

NOTE: *DO NOT FREEZE **S**erum **S**eparator **T**ube (SST) collectors (i.e. Gold Top tubes)*

SECTION 8. CHEMISTRIES

☐ Cholesterol ▲
☐ High-density lipoprotein (HDL)▲
☐ Lipid Panel▲
(Includes cholesterol, triglycerides, HDL, and calculated low-density lipoprotein (LDL))
☐ Glucose, Random {Diabetes}▲
☐ Glucose, Fasting {Diabetes}▲
____ ____. Hrs. Time since last meal

NOTE: *DO NOT FREEZE **S**erum **S**eparator **T**ube (SST) collectors (i.e. Gold Top tubes)*

▲ REQUIRED for cold shipments, if stored in an appliance prior to shipping.

Indicate REMOVAL from:

☐ FREEZER ☐ REFRIGERATOR

DATE *(mm/dd/yyyy)*	**TIME** *(hh:mm)*
	☐ AM ☐ PM

FOR DSHS LABORATORY USE ONLY

Comments:

Specimen Received: ☐ Room Temp. ☐ Cold ☐ Frozen