TEXAS Health and Human Services | Texas Department of State Health Services

Specimen Acquisition: (512) 776-7598

G-THSTEPS Specimen Submission Form (Jan 2022)

CAP# 3024401 CLIA #45D0660644

www.dshs.texas.gov/lab

****For DSHS Use Only***

FOR TEXAS HEALTH STEPS SPECIMENS ONLY !!!

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

The specimen submission form ***must*** accompany ***each*** specimen
The patient's name listed on the specimen ***must*** match the patient's name listed on the form
Specimen must have two (2) identifiers that match this form
If the Date of Collection field is not completed, the specimen will be rejected

Section 1. SUBMITTER INFORMATION (** REQUIRED)

Submitter/TPI Number **	Submitter Name **
NPI Number **	Address **
City **	State ** / Zip Code **
Phone **	Contact
Fax **	Clinic Code

Section 2. PATIENT INFORMATION (** REQUIRED)

NOTE: **Patient name** on specimen MUST match name on this form & Medicaid card.
Specimen must have two (2) identifiers that match this form.

Last Name **	First Name **	MI
Address **	Telephone Number	
City **	State ** / Zip Code **	Country of Origin
**DOB (mm/dd/yyyy) ** **	Sex ** / SSN	Pregnant? ☐ Yes ☐ No ☐ Unknown

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

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Date of Collection ** (REQUIRED)	Time of Collection ☐ AM ☐ PM	Collected By
Medical Record #/ Alien # / CUI	CDC ID	Previous DSHS Specimen Lab Number
ICD Diagnosis Code ** (1)	ICD Diagnosis Code ** (2)	ICD Diagnosis Code ** (3)

Section 3. SPECIMEN TYPE

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

NOTES:
All dates must be entered in **mm/dd/yyyy** format.
Please see the form's instructions for details on how to complete this form.
Details of test and specimen requirements can be found in the Laboratory Testing Services Manual. Visit our web site at http://www.dshs.texas.gov/lab/.

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

Section 4. ORDERING PHYSICIAN INFORMATION (** REQUIRED)

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

Section 5. PAYOR SOURCE (** REQUIRED)

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.

☒ **THSteps** (1)

Medicaid #: ** _____

Section 6. Hemoglobin and Lead (HL)

☐ **Hemoglobin**

☐ **Lead**

If this is a follow-up due to a previous abnormal or elevated result, mark "Yes" below and provide previous DSHS specimen lab number in Section 2.

☐ Yes

Section 7. STD

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

***NOTE:* DO NOT freeze Serum Separator Tube (SST) collectors (i.e. Gold Top tubes)**

Section 8. CHEMISTRIES

☐ **Cholesterol ▲**
☐ **High-density lipoprotein (HDL) ▲**
☐ **Lipid panel ▲**
(Includes cholesterol, triglycerides, HDL, and low-density lipoprotein (LDL))
☐ **Glucose, Random** {Diabetes} ▲
☐ **Glucose, Fasting** {Diabetes} ▲

***NOTE:* DO NOT FREEZE Serum Separator Tube (SST) collectors (i.e. Gold Top tubes)**
▲= If stored in an appliance prior to shipping, document **date & time** specimens were **removed from FREEZER /REFRIGERATOR** in the box below.

▲ REQUIRED for cold shipments, if stored in an appliance prior to shipping. Indicate REMOVAL from:

☐ **FREEZER** ☐ **REFRIGERATOR**

DATE (mm/dd/yyyy)	**TIME** (hr min) ☐ AM ☐ PM

FOR LABORATORY USE ONLY

Comments:

Specimen Received: ☐ Room Temp. ☐ Cold ☐ Frozen