F40-D Emergency Preparedness Specimen Submission Form's Instructions

For mailing and specimen packaging information, visit DSHS Laboratory Services webpage: www.dshs.texas.gov

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Avoid common errors:
- ✓ 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 or is inaccurate, the specimen will be rejected.
- ✓ A selection box is considered marked when filled in, checked, or crossed with an 'X'. Do not circle selection boxes.

Place DSHS Bar Code Label / Address-O-Graph Here: Place the DSHS specimen bar code label that will be used to identify and track the specimen in the DSHS laboratory information management system. If you are performing remote entry, place DSHS specimen bar code label here.

Imprint the Address-O-Graph card in this location, if applicable.

Section 1. SUBMITTER INFORMATION

All submitter information that is required is marked with double asterisks (**).

Submitter/TPI number, Submitter name and Address: The submitter number is a unique number that the Texas Department of State Health Services (DSHS) Public Health Laboratory Division assigns to each of our submitters.

To request a DSHS Public Health Laboratory Division submitter number, a master form, or to change submitter information, please call (888) 963-7111 x7578 or (512) 776-7578, or fax (512) 776-7533 or visit http://www.dshs.texas.gov/lab/mrs_forms.shtm#email.

NPI Number: Indicate the facility's 10-digit NPI Number. All health care providers must use the National Provider Identifier (NPI) number. To obtain an NPI number, contact the National Plan and Provider Enumeration System (NPPES) toll free at (800) 465-3203 or via their web site at https://nppes.cms.hhs.gov/#/

Indicate the submitter's name, address, city, state, and zip code. Please print clearly, use a pre-printed label, or use a photocopy of a master form provided by the Public Health Laboratory Division.

Contact: Indicate the name, telephone, and fax number of the person to contact at the submitting facility in case the laboratory needs additional information about the specimen/isolate.

Clinic Code: Please provide, if applicable. This is a code that the submitter furnishes to help them identify which satellite office submits a specimen and to help the submitter identify where the lab report belongs, if the submitter has a primary mailing address with satellite offices.

Section 2. PATIENT INFORMATION

Complete all patient information including last name, first name, middle initial, address, city, state, zip code, telephone number, country of origin, race, ethnicity, date of birth (DOB), sex, ICD diagnosis codes.

NOTE: The patient's name listed on the specimen *must* match the patient's name listed on the form.

All specimens must be labeled with at least two patient specific identifiers; both a primary and a secondary identifier. The identifiers must appear on both the primary specimen container (or card) and the associated submission form. Specimens that do not meet this criterion **will be considered unsatisfactory** for testing.

Acceptable Identifiers:

- Patient Name (last name, first name)
- Date of Birth
- Medical Record number
- Unique Number
- CDC Number

Information that is required to bill Medicare, Medicaid, or private insurance has been marked with double asterisks (*).   These fields must be completed. You may use a pre-printed patient label. *For anonymous HIV testing, indicate only the state, zip code, date of birth, and patient ID number.*

Date of birth (DOB): Please list the date of birth. If the date of birth is not provided or is inaccurate, the specimen may be rejected.

Pregnant: Please indicate if female patient is pregnant by marking either Yes, No, or Unknown. Pregnancy can affect some test results.

ICD diagnosis code(s): Indicate the diagnosis code(s) that would help in processing, identifying, and billing of this specimen.

Outbreak/Surveillance Date of Onset, Diagnosis/Symptoms, ~~and~~ Risk/Inpatient or Outpatient (if applicable): Tell us whether the specimen/isolate is part of an outbreak or cluster, or if the specimen is for routine surveillance. If the specimen is being submitted because of an outbreak, write in the associated name of the outbreak next to the outbreak box. If this form is being submitted for flu surveillance, the following patient information is required: Date of Onset, Date of Collection, Diagnosis/Symptoms, and Risk. Dates must be entered into the **Date of Onset** and **Date of Collection** boxes. In the **Diagnosis/Symptoms** box, list all the symptoms from the following list that apply: 1) malaise, 2) sore throat, 3) nasal congestion, 4) fever, 5) chills, 6) cough, 7) headache, 8) myalgia. In the **Risk** box, indicate whether the patient received the flu vaccine this season and the date given. **Inpatient or Outpatient** box, indicate if the patient is currently admitted to a hospital (required for TB patients).

Section 3: SPECIMEN

Date of Collection/Time of Collection: Indicate the date and time the specimen was collected from the patient. Do not give the date the specimen was sent to DSHS. **IMPORTANT: If the Date of Collection and Time of Collection fields are not completed or are inaccurate, the specimen will be rejected.**

Collected By: Clearly indicate the individual who collected the specimen.

Unique Identification number/Medical Record#/Alien#/CUI/CDC#: Provide the identification number for matching purposes. The CDC form sticker may be placed anywhere on the lower part of the form, as long as it does not obscure any tests ordered. CUI is the Clinic Unique Identifier number.

Comments/Additional ID/Previous DSHS specimen lab number: If this patient has had a previous specimen submitted to the DSHS Laboratory, please provide the DSHS lab specimen number.

Specimen Source or Type: Please indicate the type of material that you are submitting or the source of the specimen or isolate.

For specimens other than those listed, check the "Other" box and write in the site and source.

Section 4. BACTERIOLOGY RULE-OUT

This testing is to rule-out specific biothreat agents listed on form F40-D. Indicate what organism is suspected Please notify the laboratory at (956) 364-8369 prior to sending samples to expedite testing.

Section 5. PHYSICIAN INFORMATION

Ordering Physician's name and NPI Number: Give the name of the physician and the physician's NPI number. **This information is required to bill Medicaid, Medicare, and insurance.**

Section 6. PAYOR SOURCE

THE SUBMITTER WILL BE BILLED, if the required billing information is not provided, is inaccurate, or multiple payor boxes are checked**.**

Indicate the party that will receive the bill by marking only one box
- For Bacteriology rule-out, select BT GRANT
- For Molecular, select BT GRANT
- Select Zoonosis if appropriate.

Section 7. MOLECULAR STUDIES

Test Requested: You MUST check or specify the specific test(s) to be performed by the South Texas Laboratory. Each test block requires a separate form AND a separate specimen. Examples of separate blocks are "Multiplex Test" (Flu & COVID-19) "Zika, Dengue and Chikungunya"