



**G-2A Specimen Submission Form (SEP 2008) Rev 2**  
 CLIA #45D0660644  
 Laboratory Services Section  
 P. O. Box 149347, Austin, Texas 78714-9347  
 Courier: 1100 W. 49<sup>th</sup> Street, Austin, Texas 78756  
 (888) 963-7111 x7318 or (512) 458-7318  
 http://www.dshs.state.tx.us/lab

Place DSHS Bar Code Label Here

Specimen Acquisition: (512) 458-7598

**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 is REQUIRED & MUST match name on this form & Medicare/Medicaid card.

|   |  |  |                                       |  |
|---|--|--|---------------------------------------|--|
| Last Name **  |  | First Name **  |                                       | MI   |
| Address **  |  |  | Telephone Number                      |  |
| City **   |  | State **   | Zip Code **                           | Country of Origin / Bi-National ID #   |
| DOB (mm/dd/yyyy) **   | Age  | Sex  | SSN                                   | Pregnant?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown         |
| Race:<br><input type="checkbox"/> White<br><input type="checkbox"/> American Indian / Native Alaskan<br><input type="checkbox"/> Native Hawaiian / Pacific Islander |  | Ethnicity:<br><input type="checkbox"/> Black or African American<br><input type="checkbox"/> Asian<br><input type="checkbox"/> Other |                                       | <input type="checkbox"/> Hispanic<br><input type="checkbox"/> Non-Hispanic<br><input type="checkbox"/> Unknown |
| Date of Collection ** (REQUIRED)  | Time of Collection<br><input type="checkbox"/> AM<br><input type="checkbox"/> PM | Collected By   |                                       |  |
| Medical Record # / Alien # / CUI  | ICD Diagnosis Code **  | Previous DSHS Specimen Lab Number  |                                       |  |
| Date of Onset   | Diagnosis / Symptoms   | Risk   |                                       |  |
| <input type="checkbox"/> Inpatient  | <input type="checkbox"/> Outpatient  | <input type="checkbox"/> Outbreak association:   | <input type="checkbox"/> Surveillance |  |

**Section 3. SPECIMEN SOURCE OR TYPE**

|   |  |  |
|---|--|--|
| <input type="checkbox"/> Abscess (site) _____ | <input type="checkbox"/> Lesion (site) _____     | <input type="checkbox"/> Sputum: Induced     |
| <input type="checkbox"/> Blood                | <input type="checkbox"/> Lymph node (site) _____ | <input type="checkbox"/> Sputum: Natural     |
| <input type="checkbox"/> Blood: Filter paper  | <input type="checkbox"/> Nasopharyngeal          | <input type="checkbox"/> Throat swab         |
| <input type="checkbox"/> Bone marrow          | <input type="checkbox"/> Oral fluid              | <input type="checkbox"/> Tissue (site) _____ |
| <input type="checkbox"/> Bronchial washings   | <input type="checkbox"/> Plasma                  | <input type="checkbox"/> Urethral            |
| <input type="checkbox"/> Cervical             | <input type="checkbox"/> Rectal swab             | <input type="checkbox"/> Urine               |
| <input type="checkbox"/> CSF                  | <input type="checkbox"/> Serum:                  | <input type="checkbox"/> Vaginal             |
| <input type="checkbox"/> Eye                  | Acute date: ___/___/___                          | <input type="checkbox"/> Wound (site) _____  |
| <input type="checkbox"/> Feces/stool          | Conval. date: ___/___/___                        | <input type="checkbox"/> Other:              |
| <input type="checkbox"/> Gastric              |  |  |

**Section 4. REFERENCE SEROLOGY / IMMUNOLOGY**

|   |  |
|---|--|
| <input type="checkbox"/> Arbovirus (SLE / West Nile) @ ♣  | <input type="checkbox"/> Hepatitis C IgG ♣   |
| <input type="checkbox"/> Aspergillus Immunodiffusion  | <input type="checkbox"/> Legionellosis IgG \$  |
| <input type="checkbox"/> Brucellosis \$ @   | <input type="checkbox"/> Lyme disease IgG / IgM \$ @   |
| <input type="checkbox"/> Cat-scratch disease IgG \$ @   | <input type="checkbox"/> Mumps <input type="checkbox"/> IgG \$ <input type="checkbox"/> IgM @    |
| <input type="checkbox"/> Cytomegalovirus <input type="checkbox"/> IgG \$ <input type="checkbox"/> IgM | <input type="checkbox"/> Plague \$ @   |
| <input type="checkbox"/> Ehrlichia IgG \$   | <input type="checkbox"/> Q fever IgG \$  |
| <input type="checkbox"/> Fungal CF panel ♣  | <input type="checkbox"/> Rickettsial panel (RMSF, typhus) \$                                     |
| <input type="checkbox"/> Hantavirus IgG / IgM \$ @  | <input type="checkbox"/> Rubella, Syphilis, Hep B sAg ♣  |
| <input type="checkbox"/> Acute Hepatitis Panel  | <input type="checkbox"/> Rubella, Syphilis, Hep B sAg, HIV ♣                                     |
| <input type="checkbox"/> Hepatitis A (total Ab)   | <input type="checkbox"/> Rubella Screen (Title V - Family Planning)                              |
| <input type="checkbox"/> Hepatitis A IgM  | <input type="checkbox"/> Rubella <input type="checkbox"/> IgG \$ <input type="checkbox"/> IgM @  |
| <input type="checkbox"/> Hepatitis B surface Ab   | <input type="checkbox"/> Rubeola <input type="checkbox"/> IgG \$ <input type="checkbox"/> IgM @  |
| <input type="checkbox"/> Hepatitis B surface Ag   | <input type="checkbox"/> Toxoplasma <input type="checkbox"/> IgG \$ <input type="checkbox"/> IgM |
| <input type="checkbox"/> Hepatitis B core (total Ab)  | <input type="checkbox"/> Tularemia \$ @  |
| <input type="checkbox"/> Hepatitis B core IgM   | <input type="checkbox"/> Varicella Zoster IgG \$   |
| <input type="checkbox"/> Hepatitis B eAb  | <input type="checkbox"/> Other: @  |
| <input type="checkbox"/> Hepatitis B eAb  |  |

**Section 5. ORDERING PHYSICIAN INFORMATION - (\*\* REQUIRED)**

|                                    |                           |
|------------------------------------|---------------------------|
| Ordering Physician's Name **       |                           |
| Ordering Physician's NPI Number ** | Ordering Physician's UPIN |

**Section 6. PAYOR SOURCE - (REQUIRED)**

----- THE SUBMITTER WILL BE BILLED, -----  
 ----- if the required information is not provided or is inaccurate. -----

If THSteps, Medicaid, or Medicare is indicated, the Medicaid/Medicare number is required. Please write it in the space provided below.  
 If private insurance is indicated, the required billing information below is designated with an asterisk (\*).  
**Check only one box** below to indicate whether we should bill the submitter, Medicaid, Medicare, private insurance, or DSHS Program.

THSteps (1)     Medicaid (2)     Medicare (8)  
 Medicaid/Medicare #: \_\_\_\_\_

Submitter (3)     Private Insurance (4)

BT Grant (1719)     Title V - Family Planning (6)  
 HIV / STD (1608)     Title V - Prenatal Care (5143)  
 Immunizations (1609)     Title X - Family Planning (12)  
 IDEAS (1610)     Title XX - Family Planning (13)  
 Refugee (7)     Zoonosis (1620)  
 Tuberculosis (1619)     Other: \_\_\_\_\_  
 Title V - Child Health & Dental (5142)

|   |
|---|
| HMO / Managed Care / Insurance Company Name * |
| Address *                                     |
| City *    State *    Zip Code *               |

|                          |   |
|--------------------------|---|
| Responsible Party *      |   |
| Insurance Phone Number * | Responsible Party's Insurance ID Number * |
| Group Name               | Group Number                              |

"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, Laboratory Services Section."  
 Signature of patient or responsible party.

Signature \*    Date \*

|  |  |
|--|--|
| <b>Section 7. HIV / HCV SCREENING</b>  | <b>Section 8. SYPHILIS SEROLOGY</b>  |
| <input type="checkbox"/> HCV<br><input type="checkbox"/> HIV ♣<br><input type="checkbox"/> HIV Western blot only •<br>• Justification: _____ | <input type="checkbox"/> RPR only - Test of cure<br><input type="checkbox"/> RPR - Syphilis screen ♣<br><input type="checkbox"/> VDRL (CSF only)<br><input type="checkbox"/> RPR Syphilis confirmation •<br>• Justification: _____ |

|  |   |
|--|---|
| <b>Section 9. CDC REFERENCE TESTS</b>  | <b>Section 10. VIROLOGY</b>   |
| <input type="checkbox"/> Chagas disease @<br><input type="checkbox"/> Cystercercosis @<br><input type="checkbox"/> Echinococcus @<br><input type="checkbox"/> HIV-2 @<br><input type="checkbox"/> HTLV-I @<br><input type="checkbox"/> Leptospirosis @<br><input type="checkbox"/> Toxocariasis @<br><input type="checkbox"/> Other: @ | <input type="checkbox"/> Electron microscopy<br><input type="checkbox"/> Influenza surveillance<br>Vaccine received: <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Reference culture (Virus ID on isolate)<br>Suspected: _____<br>Submitted on: _____<br><input type="checkbox"/> Virus isolation (comprehensive)<br><input type="checkbox"/> Other: |

**Section 11. MOLECULAR STUDIES**

|                                    |
|------------------------------------|
| <input type="checkbox"/> PCR for:  |
| <input type="checkbox"/> PFGE for: |
| <input type="checkbox"/> Other:    |

**▲ REQUIRED for cold shipments**  
**REMOVAL from FREEZER / REFRIGERATOR**  
**DATE                      TIME**

NOTES: Each test block (ex. Virology) requires a separate form and specimen. Please see the form's instructions for details on how to complete this form. Visit our web site at <http://www.dshs.state.tx.us/lab/>.  
 ▲ = Document time & date specimens were removed from FREEZER / REFRIGERATOR in the bottom center box.  
 • Justification is required.  
 \$ = Requires acute and convalescent specimens.  
 ♣ = Reflex test(s) will be performed on positive results.  
 @ = Provide patient history on reverse side of form to avoid delay of specimen processing.

**FOR LABORATORY USE ONLY**

Specimen Received:     Room Temp.     Cold     Frozen