Specimen Acquisition: (512) 776-7598

G-2B Specimen Submission Form (Sept 2017)
CAP# 3024401 CLIA #45D0660644
Laboratory Services Section, MC-1947
P. O. Box 149347, Austin, Texas 78714-9347
Courier: 1100 W. 49th Street, Austin, Texas 78756
(888) 963-7111 x7318 or (512) 776-7318
http://www.dshs.texas.gov/lab

For DSHS Use Only
Place DSHS Bar Code Label Here

Section 1. SUBMITTER INFORMATION – (** REQUIRED)

Submitter/TPI Number ** 02180304
Submitter Name ** A P BEUTEL HLTH CTR LABORATORY
NPI Number **
Address ** 1264 TAMU
City ** COLLEGE STATION
State ** TX
Zip Code ** 77843
Phone ** (979) 458-8336
Contact
Fax ** (979) 458-8334
Clinic Code

Section 2. PATIENT INFORMATION -- (** REQUIRED)

NOTE: **Patient name** is **REQUIRED & MUST** match name on this form, Medicare/Medicaid card, & specimen container. 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 / Bi-National ID # ⊖
DOB (mm/dd/yyyy) ** | Sex ** | SSN | Pregnant? ☐ Yes ☐ No ☐ Unknown

Race: ☐ White ☐ American Indian / Native Alaskan ☐ Native Hawaiian / Pacific Islander ☐ Black or African American ☐ Asian ☐ Other
Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

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

☐ Inpatient ☐ Outpatient ☐ Outbreak association: ⊖ ☐ Surveillance ⊖

Section 3. SPECIMEN SOURCE OR TYPE – (**REQUIRED)

☐ Abdominal fluid
☐ Abscess (site) ________
☐ Blood
☐ Bone marrow
☐ Bronchial washings
☐ Cervical
☐ CSF
☐ Endocervical
☐ Eye
☐ Feces/stool
☐ Gastric
☐ Lesion (site)_________
☐ Lymph node (site)______
☐ Nasopharyngeal
☐ Plasma
☐ Rectal swab
☐ Serum
☐ Sputum: Induced
☐ Sputum: Natural
☐ Throat swab
☐ Tissue (site) __________
☐ Urethral
☒ Urine
☐ Vaginal
☐ Wound (site) __________
☐ Other: __________

Section 4. PARASITOLOGY

☐ Cryptosporidium/Cyclospora Exam
☐ Fecal Ova and Parasite Exam
☐ Malaria/Blood Parasite Exam @
☐ Schistosoma/Urine Parasite Exam @
☐ Microfilaria Exam @
☐ Microsporidia Exam
☐ Worm Identification @
☐ Other:

Section 5. BACTERIOLOGY

Clinical specimen:
☐ Aerobic isolation
☐ Anaerobic isolation
☐ Culture, stool
☐ Diphtheria Screen
☒ GC/CT, amplified RNA probe
☐ Haemophilus, isolation
☐ Toxic shock syndrome toxin I *assay (TSST 1)*

Pure culture:
☐ Anaerobic identification
☐ Organism suspected:

Definitive Identification:
☐ Bacillus ☐ Campylobacter
☐ Enteric Bacteria
☐ Gram Negative Rod
☐ Gram Positive Rod
☐ Group B Streptococcus (Beta Strep)
☐ Haemophilus
☐ Legionella
☐ Neisseria
☐ Pertussis / Bordetella
☐ Staphylococcus
☐ Streptococcus ☐ Other

Section 6. ORDERING PHYSICIAN INFORMATION – (** REQUIRED)

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

Section 7. 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. Medicare generally does not pay for screening tests-please refer to applicable Third party payor guidelines for instructions regarding covered tests, benefit limitations, medical necessity determinations and Advanced Beneficiary Notice (ABN) requirements.
4. If Medicaid or Medicare is indicated, the Medicaid/Medicare number is required. Please write it in the space provided below.
5. If private insurance is indicated, the required billing information below is designated with an asterisk (*).
6. **Check only one box** below to indicate whether we should bill the submitter, Medicaid, Medicare, private insurance, or DSHS Program.

☐ Medicaid (2) ☐ Medicare (8)
Medicaid/Medicare #:

☐ Submitter (3)
☐ BIDS (1720)
☐ BT Grant (1719)
☐ HIV / STD (1608)
☐ IDEAS (1610)
☐ Immunizations (1609)
☐ Refugee (7)
☐ TB Elimination (1619)
☐ Private Insurance (4)
☐ TIPP (5144)
☐ Title X (12)
☐ Title XX (13)
☐ TX CLPPP (9)
☐ Zoonosis (1620)
☐ Other: __________

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 *

Section 8. MOLECULAR STUDIES

PCR:
☐ Bordetella Pertussis, Parapertussis, and Bordetella holmesii detection, real-time
☐ Cyclospora Identification
☐ Malaria identification
☐ Norovirus
☐ PFGE for:
☐ Other:

Section 9. REQUIRED/REQUESTED SUBMISSIONS

☐ Corynebacterium diphtheriae ⊖
☐ E. coli O157 or other STEC serotypes ⊖
☐ EHEC, shiga-like toxin assay (Shigatoxin-producing Escherichia coli) ⊖
☐ Haemophilus influenza (from sterile sites and <5 years old) ⊖
☐ Listeria ⊖
☐ Neisseria meningitidis (from sterile sites or purpuric lesions) ⊖
☐ Outbreak stool culture ⊖
☐ Salmonella ⊖
☐ Shigella ⊖
☐ Staphylococcus aureus (VISA/VRSA) ⊖
☐ Streptococcus pneumoniae (from sterile sites and <5 years old) ⊖
☐ Vibrio cholera ⊖
☐ Vibrio sp. ⊖

NOTES: All dates must be entered in mm/dd/yyyy format. For culture ID or typing, please provide biochemical reactions on reverse side of form or attach copy of biochemistry printout. Each test section (ex. Bacteriology) 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.texas.gov/lab/.
@ = Provide patient history on reverse side of form to avoid delay of specimen processing. ⊖ = All fields indicated in Section 2 must be completed, if available.

FOR LABORATORY USE ONLY: Specimen Received: ☐ Room Temp. ☐ Cold ☐ Frozen