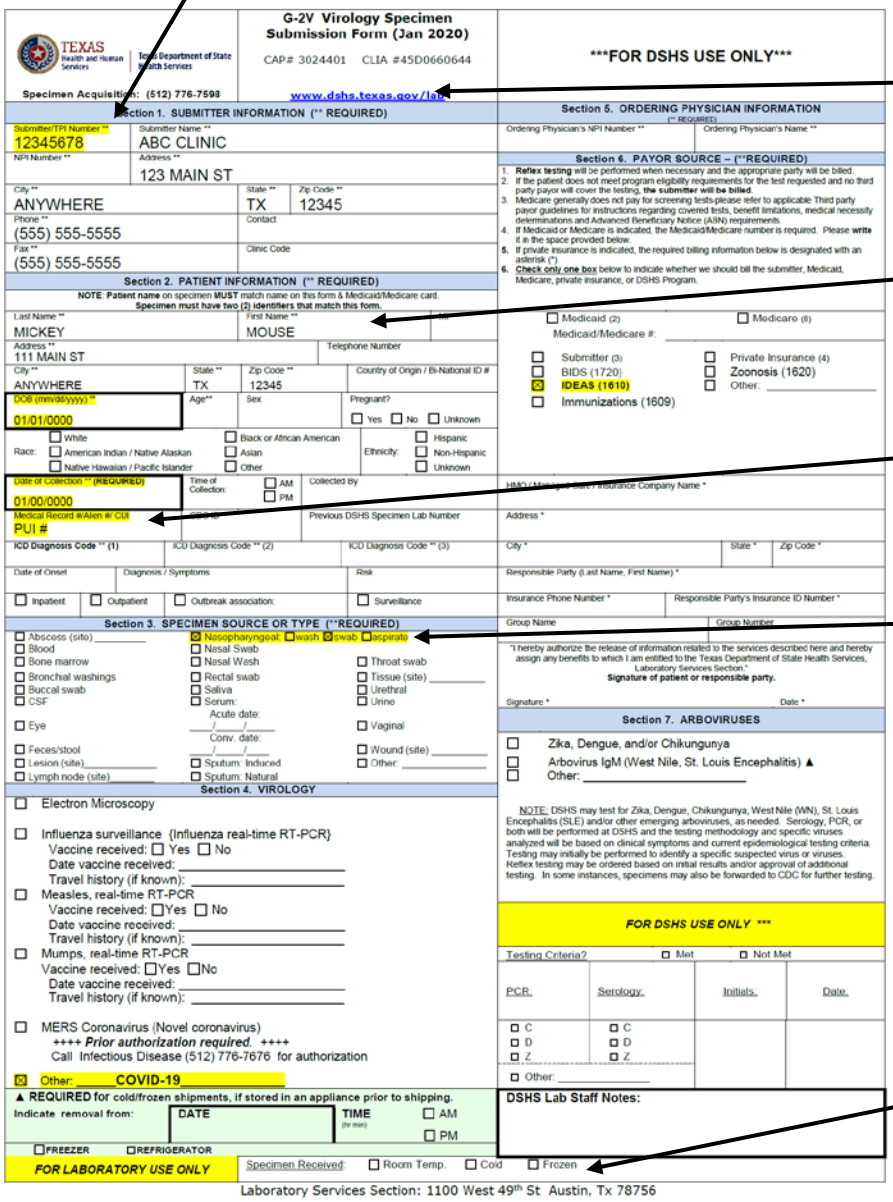
Submit one G-2V form for each specimen submitted

Submitter information must be pre-populated by Lab Reporting

Highlighted fields must be filled in correctly, otherwise testing will be delayed



G-2V Virology Specimen Submission Form (Jan 2020)

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

CAP# 3024401 CLIA #45D0660644

Specimen Acquisition: (512) 776-7593 www.dshs.texas.gov/lab

FOR DSHS USE ONLY

Section 1. SUBMITTER INFORMATION (REQUIRED)**

Submitter/TPI Number **: 12345678
Submitter Name **: ABC CLINIC
NPI Number **:
Address **: 123 MAIN ST
City **: ANYWHERE
State **: TX
Zip Code **: 12345
Phone **: (555) 555-5555
Contact:
Fax **: (555) 555-5555
Clinic Code:

Section 2. PATIENT INFORMATION (REQUIRED)**

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

Last Name **: MICKEY
First Name **: MOUSE
Address **: 111 MAIN ST
Telephone Number:
City **: ANYWHERE
State **: TX
Zip Code **: 12345
Country of Origin / Bi-National ID #:
DOB (mm/dd/yyyy) **: 01/01/0000
Age**:
Sex:
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): 01/00/0000
Time of Collection: ☐ AM ☐ PM
Collected by:
Medical Record #/Alen #/ CUI: PUI #
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)**

☐ Abscess (site) _____
☐ Blood
☐ Bone marrow
☐ Bronchial washings
☐ Buccal swab
☐ CSF
☐ Eye
☐ Feces/stool
☐ Lesion (site)_____
☐ Lymph node (site)_____
☒ Nasopharyngeal: ☐wash ☒swab ☐aspirate
☐ Nasal Swab
☐ Nasal Wash
☐ Rectal swab
☐ Saliva
☐ Serum:
Acute date: ___/___/___
Conv. date: ___/___/___
☐ Sputum: Induced
☐ Sputum: Natural
☐ Throat swab
☐ Tissue (site) _____
☐ Urethral
☐ Urine
☐ Vaginal
☐ Wound (site) _____
☐ Other: _____

Section 4. VIROLOGY

☐ Electron Microscopy
☐ Influenza surveillance (Influenza real-time RT-PCR)
Vaccine received: ☐ Yes ☐ No
Date vaccine received: _____
Travel history (if known): _____
☐ Measles, real-time RT-PCR
Vaccine received: ☐Yes ☐ No
Date vaccine received: _____
Travel history (if known): _____
☐ Mumps, real-time RT-PCR
Vaccine received: ☐Yes ☐No
Date vaccine received: _____
Travel history (if known): _____
☐ MERS Coronavirus (Novel coronavirus)
++++ *Prior authorization required.* ++++
Call Infectious Disease (512) 776-7676 for authorization
☒ Other: COVID-19

▲ REQUIRED for cold/frozen shipments, if stored in an appliance prior to shipping.
Indicate removal from: DATE TIME (hr min) ☐ AM ☐ PM
☐FREEZER ☐REFRIGERATOR

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

Section 5. ORDERING PHYSICIAN INFORMATION (REQUIRED)**

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

Section 6. 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)
☒ IDEAS (1610)
☐ Immunizations (1609)
☐ Private Insurance (4)
☐ Zoonosis (1620)
☐ Other:
HMO / Managed Care / Insurance Company Name *:
Address *:
City *:
State *:
Zip Code *:
Responsible Party (Last Name, First Name) *:
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 7. ARBOVIRUSES

☐ Zika, Dengue, and/or Chikungunya
☐ Arbovirus IgM (West Nile, St. Louis Encephalitis) ▲
☐ Other: _____

NOTE: DSHS may test for Zika, Dengue, Chikungunya, West Nile (WN), St. Louis Encephalitis (SLE) and/or other emerging arboviruses, as needed. Serology, PCR, or both will be performed at DSHS and the testing methodology and specific viruses analyzed will be based on clinical symptoms and current epidemiological testing criteria. Testing may initially be performed to identify a specific suspected virus or viruses. Reflex testing may be ordered based on initial results and/or approval of additional testing. In some instances, specimens may also be forwarded to CDC for further testing.

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Testing Criteria? ☐ Met ☐ Not Met

PCR	Serology	Initials	Date
☐ C ☐ D ☐ Z	☐ C ☐ D ☐ Z		
☐ Other: _____			

DSHS Lab Staff Notes:

Laboratory Services Section: 1100 West 49th St Austin, Tx 78756

Contact Lab Reporting or Email labinfo@dshs.texas.gov to request a submitter number

Patient specific identifiers must match on both specimen and form

PUI# must be listed in the Medical Record field

Source on specimens must match source on form. Preferred Source: Nasopharyngeal Swab

If shipped cold, specimen must be received cold within 72 hours from the time of collection, otherwise freeze and ship on enough dry ice to be received frozen

Any Questions? Contact DSHS Coronavirus hotline at 1-800-570-9779 or www.dshs.texas.gov/coronavirus