



Texas Department of State Health Services

F40-B Specimen Submission Form (Jan 2020)

CLIA #45D0503753 CAP #2148801

www.dshs.texas.gov/lab/so_tx_lab

Place DSHS Bar Code Label / Address-O-Graph Here

P: (956) 364-8746 FAX: (956) 412-8794

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 & Medicare/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, Sex, SSN, Pregnant?, Race, Ethnicity, Date of Collection, Time of Collection, Medical Record #, CDC ID, Previous DSHS Specimen Lab No.

Section 3. ORDERING PHYSICIAN INFORMATION - (** REQUIRED)

Ordering Physician's NPI Number, Ordering Physician's Name

Section 4. PAYOR SOURCE - (**REQUIRED)

- 1. Reflex testing will be performed when necessary... 2. If the patient does not meet program eligibility requirements... 3. Medicare generally does not pay for screening tests... 4. If Medicaid or Medicare is indicated... 5. If private insurance is indicated... 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 #, IDEAS, BIDS (1700), Bivalent (1719), HIV / STD (1608), OPC, Private Insurance (4), TB Elimination (1619), Zoonosis (1620), Other

ICD Diagnosis Code (1, 2, 3), Inpatient/Outpatient, Date of Onset, Diagnosis / Symptoms, Risk

HMO / Managed Care / Insurance Company Name, Address, City, State, Zip Code

Section 5. SPECIMEN SOURCE OR TYPE - (REQUIRED for Mycobacteriology specimens)

Abscess (site), Blood, Bone marrow, Bronchial washings, CSF, Eye, Feces/stool, Gastric, Lesion (site), Lymph node (site), Nasopharyngeal, Plasma, Rectal swab, Serum, Sputum: Induced, Sputum: Natural, Throat swab, Tissue (site), Urine, Vaginal, Wound (site), Other

Responsible Party (Last Name, First Name), Insurance Phone Number, Responsible Party's Insurance ID Number, Group Name, Group Number, Signature of patient or responsible party, Date

Section 6. SEROLOGY

Syphilis (RPR) screen (qualitative), Syphilis (RPR) titer (quantitative), Syphilis TP-PA, Justification

Section 7. MYCOBACTERIOLOGY

AFB Culture, AFB Smear only, AFB Concentration, Direct NAAT for M. tuberculosis (Respiratory Diagnostic Specimen Only), Identification of AFB isolate, DNA Probe, Identification, referred isolates, DNA Probe, MGIT Susceptibility (each drug), MGIT Susceptibility (each drug) PZA, Conventional Susceptibility (each drug)

Section 8. MOLECULAR STUDIES

PCR, Influenza

Section 9. ZIKA, DENGUE, CHIKUNGUNYA

Zika, Dengue, and/or Chikungunya, NOTE: Serology, PCR, or both will be performed at DSHS... Testing Criteria? Met/Not Met, PCR, Serology, Initials, Date

NOTES: * = Justification required if TP-PA is requested regardless of RPR results. ▲ = Document time & date specimens were removed from FREEZER / REFRIGERATOR... ◆ For pure culture ID and typing, please provide biochemical reactions on reverse side of form...

REQUIRED for cold/frozen shipments, if stored in an appliance. Indicate removal from: FREEZER, REFRIGERATOR, DATE, TIME

LABORATORY TEST RESULTS SECTION - FOR LABORATORY USE ONLY

Table with columns: TEST, NONREACTIVE, REACTIVE, TITER. Rows: RPR, TP-PA

Results for the TP-PA are inconclusive due to nonspecific hemagglutination in serum control.

UNSATISFACTORY:

Broken in Mail, Hemolyzed, Leaked in Transit, Name Discrepancy, No Specimen Received, Quantity Not Sufficient, Thyroid, Please resubmit

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