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

Specimen Acquisition: (512) 776-7598

G-1B Specimen Submission Form (Jan 2020)

CAP# 3024401 CLIA #45D0660644

www.dshs.texas.gov/lab

****For DSHS Use Only***

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 & Medicaid/Medicare 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 (mm/dd/yyyy) **	Sex **	SSN	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)	Time of Collection ☐ AM ☐ PM	Collected By	
Medical Record # / Alien # / CUI	CDC ID	Previous DSHS Specimen Lab Number	
ICD Diagnosis Code ** (1)	ICD Diagnosis Code ** (2)	ICD Diagnosis Code ** (3)	
☐ Inpatient	☐ Outpatient	☐ Outbreak association:	☐ Surveillance
Date of Onset (mm/dd/yyyy)	Diagnosis / Symptoms	Risk	

Section 3. SPECIMEN TYPE

☐ Blood: Capillary ☐ Blood: Venous ☐ Other:
☐ Blood: Filter Paper ☐ Serum

Section 4. HEMOGLOBIN TYPE

☐ **Hemoglobin electrophoresis**
(Accepted on Snap-Apart Card only)

Section 5. PKU DIETARY MONITORING

☐ **Phenylalanine / Tyrosine**
(Does not include full NBS panel)

Section 6. HL

☐ **Hemoglobin**
☐ **Lead**

If this is a follow-up due to a previous abnormal or elevated lead result, mark "Yes" below and provide previous DSHS specimen lab number in Section 2.
☐ Yes

Section 7. CHEMISTRIES

***NOTE:* DO NOT FREEZE Serum Separator Tube (SST) collectors (i.e. Gold Top tubes)**

☐ **Creatinine ▲**
☐ **Cholesterol ▲**
☐ **High-density lipoprotein (HDL) ▲**
☐ **Lipid panel ▲**
(Includes cholesterol, triglycerides, HDL, and low-density lipoprotein (LDL))

Diabetes:
☐ **Glucose, Random ▲**
☐ **Glucose, Fasting ▲**
__ __.__ **hrs.** Time since last meal

NOTES: All dates must be entered in mm/dd/yyyy format.
Please see the form's instructions for details on how to complete this form. Details of test and specimen requirements can be found in the Laboratory Testing Services Manual. Visit our web site at http://www.dshs.texas.gov/lab/ .

▲= If stored in an appliance prior to shipping, document **date & time** specimens were **removed from FREEZER / REFRIGERATOR** in the box below.

For assistance or questions, email ClinicalChemistry@dshs.texas.gov

Section 8. ORDERING PHYSICIAN INFORMATION (** EQUIRED)

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

Section 9. 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. **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) ☐ Private Insurance (4)
☐ BIDS (1720) ☐ Title XX (13)
☐ HIV / STD (1608) ☐ Other: ____________
☐ TB Elimination (1619)

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 10. DNA ANALYSIS

☐ **Galactosemia: Common Mutation Panel**
☐ **Cystic Fibrosis: Mutation Panel**
☐ **MCAD: Mutation Panel**
☐ **VLCAD: Gene Sequencing**
☐ **X -ALD: Targeted Sequencing**
☐ **X-ALD: Full Gene Sequencing**
☐ **Hemoglobin DNA Test:**
Hb S, C, E, D, or O-Arab
Common Beta-Thalassemia Mutation
Beta-Globin Gene Sequencing

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

FOR LABORATORY USE ONLY

Comments:

Specimen Received: ☐ **Room Temp.** ☐ **Cold** ☐ **Frozen**

SAMPLE DO NOT USE