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

Specimen Acquisition: (512) 776-7598

G-2E –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 MUST** match name on this form & specimen container**. Specimen must have two (2) patient-specific 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	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 ** **	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)
Date of Onset	Diagnosis / Symptoms	Risk

☐ Outbreak association: ☐ Surveillance

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

☐ Abscess (site) _____	☐ Gastric	☐ Throat swab
☐ BAL		
☐ Blood	☐ Lesion (site)_____	☐ Tissue (site) _____
☐ Bone marrow	☐ Lymph node (site) _____	☐ Urethral
☐ Bronchial washings	☐ Nasopharyngeal	☐ Urine
☐ Cervical	☐ Plasma	☐ Vaginal
☐ CSF	☐ Rectal swab	☐ Wound (site) _____
☐ Endocervical	☐ Serum	☐ Swab Site:_____
☐ Eye	☐ Sputum: induced	_____
☐ Feces/stool	☐ Sputum: natural	☐ Other: _____

Section 5. ORDERING PHYSICIAN INFORMATION

Ordering Physician's NPI Number	Ordering Physician's Name

Section 6. PAYOR SOURCE

☒ CDC Special Project (14)

Comments/Notes:
Reflex testing will be performed when necessary

Section 7. COLLECTION SITE INFORMATION

CLIA#	
Collection Site Name**	Collection Site Sample Number**
Collection Site Infection Control Contact Name	
Collection Site Infection Control Contact Phone Number	
Zip Code	Collection Site Sample Number

Section 4. TEST REQUESTED (**REQUIRED)

Select Box 1 or 2

BOX 1

☐ Isolates

Print the name of the organism: _____

Check the box for **one** of the test options below:

- ☐ Candida identification by MALDI (Candida susceptibility may be performed)
- ☐ CRAB: Carbapenem Resistant Acinetobacter
- ☐ CRE: Carbapenem Resistant Enterobacteriaceae
- ☐ CRPA: Carbapenem Resistant Pseudomonas Aeruginosa

****Attach copy of previous lab results**

BOX 2

☐ **Colonization Testing Only Print the name of the suspected Organism** (i.e. Candida auris, CRAB, CRE, CRPA, other):

: _____

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. Visit our web site at http://www.dshs.texas.gov/lab/.

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