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

Specimen Acquisition: (512) 776-7598

G-2E –Specimen Submission Form (Jan 2022)

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, 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	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) _____
☐ BAL
☐ 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) _____
☐ Swab (site)_____
_____
☐ Other: _____

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 Enterobacterales

☐ 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):

: _____

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 perfotmed when necessary

Section 7. COLLECTION SITE INFORMATION

CLIA#

Collection Site Name**

Collection Site Infection Control Contact Name

Collection Site Infection Control Contact Phone Number

Zip Code	Collection Site Sample Number**

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