Specimen Acquisition: (512) 458-7598

G-1B **Specimen Submission Form (MAR 2006) Rev 6**
CLIA #45D0660644

Laboratory Services Section
1100 W. 49th Street, MC-1947
Austin, Texas 78756-3194
(888) 963-7111 x7318 or (512) 458-7318
http://www.dshs.state.tx.us/lab

Place Bar Code Label Here

SAMPLE

Section 1. SUBMITTER INFORMATION – (** REQUIRED)

Submitter/TPI Number ** | Submitter Name **
NPI Number ** | Addre…
City ** | …te ** | … **
Phon… | …Contact
Fax | …linic Code

…ction 2. PA… IN…ATION …

N… specimen is …RED … match na… …is… …re… …d card
Last N… | First Nar…
Address ** | …one
City ** | Zip C… | …ount… …gin
Rac… | …hite | …ican … | …anic | …rica… | …Nativ… | As… | E… | …Hispa… | …Paci… | …r | Ot… | …own
DOB … | SSN ** | Pregnant? ☐ Yes ☐ No ☐ Unknown
Date of Co… …EQUIRED) | Time of Collection | Collected By
Medical Record Number | ICD Diagnosis Code ** | Previous DSHS Specimen Lab Number

Section 3. SPECIMEN TYPE

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

Section 4. CLINICAL CHEMISTRY

NOTES: ▲= For cholesterol, lipid profile, & glucose testing document **time & date** specimens were **removed from FREEZER / REFRIGERATOR** in the lower right-hand box.

♠ = Tests covered by THSteps or Title V Well-Child Health Programs.

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 Services Section's Manual of Reference Services. Visit our web site at http://www.dshs.state.tx.us/lab/.

Hyperlipidemia ▲ ♠
- ☐ **Fasting** (1)
- ☐ **Non-fasting** (2) (Total cholesterol, HDL)

- ☐ **Total Hemoglobin ♠**
- ☐ **Hemoglobin electrophoresis ♠**
- ☐ **Lead testing ♠**

- ☐ **HDN Screening (Rhogam) ▲**
(Includes ABO, Rh, & Antibody screen testing)
Do NOT Freeze.

Has patient received Rh_o(D) Immunoglobulin within the past 6 mo.?
☐ Yes ☐ No

If yes, date: ____
Weeks gestation: ____

Reflex testing (AB type & titer) will be performed on positive antibody screens.

Diabetes ▲ ♠
- ☐ **Random** (1)
- ☐ **Fasting** (2)
- ☐ **2 Hr. Post prandial** (3)

Glucose tolerance ▲ ♠
- ☐ **Fasting** (4)
- ☐ **2 Hr.** (7)
- ☐ **1 Hr.** (6)
- ☐ **3 Hr.** (8)

__ __.__ **hrs.** Time since last meal

- ☐ **Syphilis (RPR) ♠**
- ☐ **Total cholesterol ▲ ♠**
- ☐ **Lipid profile ▲ ♠**

…5. PHY… INFORMATI… …)

…e ** | …* | Physician's NP… **

…on … …OR SOURCE – …UIRED)

…dicate w… …e sho… …submitter, Medicaid… …nce, or …SHS P… … Med… …edicare is indicated, … …mber …s requi… …e cop… …rd must be attached… …SHS … Prog… …ated, …ed billing informatio… …an …asteris… …quired information is… …MITTER WILL BE B…

- ☐ …mitter
- ☐ …edicaid
- ☐ Pr… …surance
- ☐ M…
- …edicaid/Medicare (attach copy of card)
- …am…
- ☐ THSteps
- ☐ NBS Case M…
- ☐ Refugee
- ☐ TX CLPPP
- ☐ …itle …
- ☐ …itle …
- ☐ …itle X – Family Planning
- ☐ Title XX – Family Planning
- ☐ Other: ____

HMO / Managed Care / Insurance Company Name *
Address *
City * | State * | Zip Code *
Responsible Party *
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. NEWBORN REFERENCE TESTING

☐ **Phenylalanine**

Section 8. DNA ANALYSIS +++ Preauthorization required +++

Phenylketonuria:
- ☐ **Full Mutation Analysis**
- ☐ **Carrier Mutation Analysis**

Hemoglobin DNA Test: ____

Clinical diagnosis: ____

▲ REQUIRED for cold shipments
REMOVAL from FREEZER / REFRIGERATOR

DATE	TIME

FOR LABORATORY USE ONLY

Specimen Received: ☐ Room Temp. ☐ Cold ☐ Frozen