TEXAS Department of State Health Services

Laboratory Services Section
1100 W. 49th Street, MC #1947
Austin, Texas 78756-3194
(888) 963-7111 x7318 or (512) 458-7318

CLIA #45D0660644

T-1 Newborn Screening Thyroid Submission Form (APR 2005)

Please indicate the DSHS Receiving Laboratory:

☐ **Regional Clinical Laboratory in Austin (RCLA)** 4110 Guadalupe Austin, TX 78751 Phone: (512) 419-2029 Fax: (512) 419-2039 CAP LAP Number: 2153701 CLIA Number: 45D0505790	☐ **Texas Center for Infectious Diseases (TCID) - Women's Health Laboratory** 2303 South East Military Drive San Antonio, Texas 78223 Phone: (210) 531-4596 Fax: (210) 531-4502 CAP LAP Number: 2140102 CLIA Number: 45D0911298	☐ **South Texas Laboratory** 1301 Rangerville Road Harlingen, TX 78552 Phone: (956) 444-3310 Fax: (956) 412-8794 CAP LAP Number: 2148801 CLIA Number: 45D0503753

SAMPLE

Section 1: SUBMITTER INFORMATION

Submitter/TPI Number	Submitter Name	
Address		
City	State	Zip Code
Phone	Contact	
Fax	Clinic Code	

Section 2: PATIENT INFORMATION (**REQUIRED Fields)

NOTE: **Patient name** on specimen is **REQUIRED & MUST** match name on form.

Last Name**	First Name**	MI	
Address**			
City**	State**	Zip Code**	Country of Origin

Race:
- ☐ White
- ☐ American Indian / Native Indian
- ☐ Native Hawaiian / Pacific Islander
- ☐ Black or African American
- ☐ Asian
- ☐ Other

Ethnicity:
- ☐ Hispanic
- ☐ Non-Hispanic
- ☐ Unknown

DOB (mm/dd/yy)**	Age	Sex**	SSN**
Specimen Collection Facility	Collected by		
Date of Collection**	Time of Collection		
Patient ID Number	ICD Diagnosis Code 243	Previous Specimen Lab #	

Section 3: TEST

☐ Thyroid Profile ☐ T4 ☐ Free T4 ☐ TSH

Section 4: PHYSICIAN INFORMATION – **REQUIRED

Physician's Name**	Physician's UPIN**

Section 5: PAYOR SOURCE - REQUIRED

Indicate whether we should bill the submitter, Medicaid, Medicare, private insurance, or DSHS Program. If Medicaid or Medicare is selected, the Medicaid/Medicare number is required. If private insurance or DSHS Program is selected, the required billing information below is indicated with an (*). If required information is not provided,
THE SUBMITTER WILL BE BILLED.

- ☐ Submitter
- ☐ Medicaid
- ☐ Private Insurance
- ☐ Medicare
- ☐ DSHS Program: Newborn Screening Case Management

Medicaid/Medicare #:

HMO / Managed Care / Insurance Company Name*		
Address*		
City*	State*	Zip Code*
Responsible Party*		
Insurance Phone Number*	Responsible Party's Insurance ID #*	
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*

NOTES: 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/.

FOR LABORATORY USE ONLY

Specimen Received: ☐ Room Temp. ☐ Cold ☐ Frozen ☐ **Fax Results to NBS Case Management at (512) 458-7421**