TEXAS Department of State Health Services

Prenatal Screening: (800) 687-4363

G-1C **Specimen Submission Form (MAR 2006) Rev 2**

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 **	ress
City **	State ** / Zi
Phone	
Fax	

Section 4. PHY N INFORMATIO)

ne **

** | Phy PI Number **

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Subr ☐ ate Insurance
Medi ☐ icare

Medicaid/Medicar
(attach copy of card)

am

☐ Title V – Fan ☐
☐ Title V – MC
☐ Title X – Fan
☐ Title XX – Fa

Section 2. PA MATION IR

N e on specimen is RED match na hi & re id card

Last N	t N		
Address	e N		
City **	**	e **	of Orig

Race: ☐ White ☐ Asian ☐ Bl frica ican ☐ Ame ian / Alaskan ☐ As ☐ Ot ... ian Islander

Ethnicity: ☐ ...c ☐ ...spanic ☐ Semitic ☐ Chinese ☐ ...ind ☐ Korean ☐ Oriental ☐ Multiple ☐ Not Specified ☐ Unknown

DOB (mm/dd/yyyy) **	Age	Sex	SSN **	Pregnant? ☐ Yes ☐ No ☐ Unknown

Medical Record Number	ICD Diagnosis Code **	Previous DSHS Specimen Lab Number

HMO / Managed Care / Insurance Company Name *

Address *

City *	State *	Zip Code *

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 3. TRIPLE SCREEN REQUEST & PATIENT INFORMATION

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/.

(All information is required for testing.)

O.B. History G__________ P__________ AB__________

	Yes	No	
Multiple fetuses?	☐	☐	Specify *number of fetuses:* ________
On insulin **prior to** pregnancy (IDDM)	☐	☐	
Maternal medication	☐	☐	Specify: ________
Repeat specimen?	☐	☐	If yes, indicate reason: ________

Gestational Age (Select one calculation method.)

☐ DATE of LMP ________ (mm/dd/yy)
☐ Ultrasound dating _____ weeks _____ days on ________ (mm/dd/yy)
☐ If sono by 1/10 of week ___.___ weeks on ________ (mm/dd/yy)
☐ Physical exam _____ weeks _____ days on ________ (mm/dd/yy)
☐ Estimated Delivery Date ________ (mm/dd/yy) by: US____LMP____ Exam____

CURRENT WEIGHT	DATE OF COLLECTION	TIME OF COLLECTION	COLLECTED BY	Time and Date of Removal from Freezer prior to shipping (REQUIRED)

FOR DSHS LABORATORY USE ONLY

Specimen received

Specimen condition

Verify specimen

Edit

Completed

Mailed & faxed

Revised, mailed & faxed

Revised, mailed & faxed