G-27A Emergency Preparedness Specimen Submission Form Instructions

For mailing and specimen packaging information, visit DSHS Laboratory Services Section's web page at http://www.dshs.texas.gov/lab/.

The specimen submission form ***must*** accompany each specimen.
The patient's name listed on the specimen ***must*** match the patient's name listed on the form.
Specimen must have two (2) identifiers that match the form.
If the Date of Collection field is not completed or is inaccurate, the specimen will be rejected.

Section 1. SUBMITTER INFORMATION

All submitter information that is required is marked with double asterisks (**).

Submitter/TPI number, Submitter Name and Address: The submitter/TPI number is a unique number that the Texas Department of State Health Services (DSHS) Laboratory Services Section assigns to each of our submitters. To obtain a Texas Provider Identifier (TPI) number, contact Texas Medicaid and Healthcare Partnership (TMHP) at 1-800-925-9126.

To request a DSHS Laboratory Services Section submitter number, a master form, or to update submitter information, please call (888) 963-7111 x7578 or (512) 776-7578, or fax (512) 776-7533 or visit http://www.dshs.texas.gov/lab/mrs_forms.shtm#email.

NPI Number: Indicate the facility's 10-digit NPI number. All health care providers must use the National Provider Identifier (NPI) number. To obtain an NPI number, contact the National Plan and Provider Enumeration System (NPPES) toll free at (800) 465-3203 or via their web site at https://nppes.cms.hhs.gov/NPPES/Welcome.do.

Contact Information: Indicate the name, telephone number, and fax number of the person to contact at the submitting facility in case the laboratory needs additional information about the specimen/isolate.

Clinic Code: Please provide, if applicable. This is a code that the submitter furnishes to help them identify which satellite office submits a specimen and to help the submitter identify where the lab report belongs, if the submitter has a primary mailing address with satellite offices.

Section 2. PATIENT INFORMATION

Complete all patient information including last name, first name, middle initial, address, telephone number, city, state, zip code, country of origin, date of birth (DOB), sex, social security number (SSN), pregnant, race, ethnicity, date and time of collection, collected by, medical record number, previous DSHS specimen lab number, ICD diagnosis code, date of onset, diagnosis/symptoms, risk, mark either inpatient/outpatient, outbreak association, and/or surveillance.

NOTE: The patient's name listed on the specimen *must* match the patient's name listed on the form.

All specimens must be labeled with at least two patient specific identifiers; both a primary and a secondary identifier. The identifiers must appear on both the primary specimen container (or card) and the associated submission form. Specimens that do not meet this criterion **will be considered unsatisfactory** for testing.

Acceptable identifiers are listed below:

List of Acceptable Identifiers (2 identifiers are required to make a positive ID)	**Identifier Type** (Patient Name + at least 1 secondary ID)
Patient Name (last name, first name)	Primary **(required)**
Date of Birth	Secondary **(preferred)**
Medical Record Number	Secondary
Social Security Number	Secondary
Medicaid Number	Secondary
Newborn Screening Kit Number	Secondary
CDC Number	Secondary

Information that is has been marked with double asterisks (**). These fields must be completed. You may use a pre-printed patient label.
Patient Name: The name on the specimen form and specimen must match
Date of birth (DOB): Please list the date of birth**.** If the date of birth is not provided, the specimen may be rejected.
Pregnant: Indicate if female patient is pregnant by marking either Yes, No, or Unknown.

Date of Collection/Time of Collection: Indicate the date and time the specimen was collected from the patient or other source. Do not give the date the specimen was sent to DS. **IMPORTANT: If the Date of Collection field is not completed or is inaccurate, the specimen will be rejected.**

Collected By: Clearly indicate the individual who collected the specimen.

Medical Record # / Alien # / CUI: Provide the identification number for matching purposes. CUI is the Clinic Unique Identifier number.

Previous DSHS Specimen Lab Number: If this patient has had a previous specimen submitted to the DSHS Laboratory, please provide the DSHS specimen lab number.

ICD Diagnosis Code(s), Country of Origin, Date of Onset, Diagnosis/Symptoms, and Risk (if applicable): Indicate the diagnosis code or findings that would help in processing, identifying, and billing of this specimen/isolate. If the patient's country of origin is not the U.S., then please provide the patient's country of origin.

Inpatient or Outpatient (if applicable): Indicate if the patient is currently admitted to a hospital (required for TB patients).

Outbreak/Surveillance (if applicable): Tell us whether the specimen/isolate is part of an outbreak or cluster, or if the specimen is for routine surveillance. If the specimen is being submitted because of an outbreak, write in the associated name of the outbreak next to the outbreak box.

Section 3. SPECIMEN SOURCE OR TYPE

Specimen Source or Type: Indicate the kind of material you are submitting or the source of the specimen or isolate.

For specimens other than those listed, check the "Other" box and write in the source or type.

++++ **Botulism Only** ++++**:** Use this only for specimens submitted for *Clostridium botulinum* testing. For infant testing send 10 g stool, do **not** send sera. For adult testing send a minimum of 10 ml sera and/or 50 g stool. For wound testing send 2 swabs in anaerobic transport medium. Ship stools cold (not frozen). Ship sera cold unless it will be received > 48 hours from collection then ship frozen. Ship wound swabs at room temp. Specimen source is a required field for botulism testing.

TEST

Test Requested: You **MUST** check or specify the specific test(s) to be performed by the DSHS Laboratory Services Section. Each test block requires a separate form AND a separate specimen. Examples of separate blocks are "Clostridium botulinum" "Bacteriology" or "Chemical Terrorism". For specific test instructions, see the Laboratory Services Section Manual of Reference Services. To cancel a test that is marked in error on the form, mark one line through the test name, write "error" and initial.

Section 4. CLOSTRIDIUM BOTULINUM

Check the box marked "Clostridium botulinum" and check the appropriate patient symptom(s) boxes.

++++ **Prior authorization required** ++++**:** Before specimens can be submitted for *Clostridium botulinum* testing, a DSHS botulism epidemiologist consult is required. The physician should call the switchboard at (512) 776-7111 to talk to a DSHS epidemiologist for a consult. An authorization code and authority name will then be supplied if the epidemiologist approves the testing. Please write the authorization code and authorization authority name in the appropriate lines on the form. Check the *Clostridium botulinum* box and check the appropriate patient symptoms. Make sure to include both a contact phone number and pager number in Section 6 "Ordering Physician Information" to facilitate communication between the ordering physician and the botulism epidemiologist(s).

Section 5. BACTERIOLOGY RULE-OUT / PCR

This testing is to rule-out specific biothreat agents listed on form G-27A. Do not use this form for regular bacteriological testing. For regular bacteriological testing, use the G-2B form. Please notify the laboratory at (512) 776-3781 prior to sending samples to expedite testing.

Under the "Bacteriology" section of the form:

1. Under "Definitive Identification:"
   a. If a suspected agent is isolated and a pure culture is being submitted, please check the appropriate organism identification box for rule-out purposes.
2. Under "Clinical specimen:"
   a. Check the box marked "Aerobic Culture", if the specimen is a clinical sample. Under "Organism suspected", please hand write the organism suspected for rule-out purposes. For botulism testing complete "Section 4. Clostridium botulinum" do not use Section 5. "Bacteriology".
3. Under "Molecular Studies (PCR):"
   a. Check the box corresponding to the suspected organism. For suspect smallpox cases, please check the appropriate smallpox symptom(s) boxes.
   b. For Bacillus cereus suspected of containing anthrax genes (associated with severe illness or death):
      i. Cases of Bacillus cereus that contained anthrax genes included some of the following symptoms:
      ii. Fever, chills, difficulty breathing, cough, coughing blood, nausea, abdominal pain, vomiting, diarrhea, pneumonia, hypoxia, chest pain, respiratory failure, headache, malaise, acidosis, black eschar skin lesion, altered mental status, and acute renal failure.
      iii. If an isolate is identified as B. cereus, and follow up on the patient's condition reveals death or serious illness with the above symptoms, please send the isolate to the DSHS BioThreat team for a PCR screen for anthrax genes.

Section 6. ORDERING PHYSICIAN INFORMATION

Ordering Physician's Name and NPI Number: Give the name of the physician and the physician's NPI number. Make sure to include both a contact phone number and pager number in Section 6 "Ordering Physician Information" for botulism samples to facilitate communication between the ordering physician and the botulism epidemiologist(s).

Section 7. PAYOR SOURCE

Indicate the party that will receive the bill by marking only one box.

- For C. botulinum/Botulism, select IDEAS.
- For Bacteriology rule-out or PCR, select BT GRANT.
- Select Zoonosis if appropriate.

Section 8. CHEMICAL TERRORISM

In the event of a suspected chemical terrorism event only blood, serum and urine samples may be sent for clinical chemical threat testing. This **IS NOT** for the routine testing of blood, serum and urine. Justification **IS** a required field and must be completed for samples to be tested. Please notify the laboratory at (512) 689-9945 prior to sending samples to expedite testing and to obtain a justification code. Upon receiving the justification code, biological specimen matrix shipping criteria will be forwarded. Please indicate all patient clinical symptoms and physician diagnoses in the section and/or attach additional supporting documentation upon sample submission.

REFLEX & REFERENCE TESTING:

Please note that additional testing procedures (i.e., reflex testing) will be performed at the request of the submitter. Reflex testing will be billed to the appropriate payor in addition to the original test requested. This is particularly applicable to microbiology testing and other laboratory testing requiring confirmation or further diagnostic work.

All reference tests will be billed to the submitter at the prevailing reference laboratory's price with the addition of a handling fee.

For specific test instructions and information about tube types, see the Laboratory Services Section Laboratory Testing Services Manual on our web site at **http://www.dshs.state.tx.us/lab/**.