

CHAIN OF CUSTODY
Houston Health Department Laboratory
2250 Holcombe Blvd.
Houston, TX 77030

SECTION 1 (Section 1 should be completed by initial specimen handler)

Agency Case ID/Patient MR Number: _____
Date: _____ Time: _____ Phone: (_____) _____
Received By: _____ (Print Name) _____ (Signature)
Organization: _____ (Print FULL Name – No Acronyms, Please)
Complete Address: _____ (Number and Street) _____ (City) _____ (Zip Code)

SECTION 2 (Section 2 should be completed by specimen transporter/courier followed by intended specimen recipient(s))

Date: _____ Time: _____ Phone: (_____) _____
Received By: _____ (Print Name) _____ (Signature)
Organization: _____ (Print FULL Name – No Acronyms, Please)

Date: _____ Time: _____ Phone: (_____) _____
Received By: _____ (Print Name) _____ (Signature)
Organization: _____ (Print FULL Name – No Acronyms, Please)

Date: _____ Time: _____ Phone: (_____) _____
Received By: _____ (Print Name) _____ (Signature)
Organization: _____ (Print FULL Name – No Acronyms, Please)

Date: _____ Time: _____ Phone: (_____) _____
Received By: _____ (Print Name) _____ (Signature)
Organization: _____ (Print FULL Name – No Acronyms, Please)

Date: _____ Time: _____ Phone: (_____) _____
Received By: _____ (Print Name) _____ (Signature)
Organization: _____ (Print FULL Name – No Acronyms, Please)