JHMI Point-of-Care Testing Program

DISCONTINUATION OF POINT-OF-CARE TEST(S) FORM

This Form must be signed by both the Medical Director and Nurse Manager before the Point-of-Care Testing Program Office processes the request.

SECTION A: To Be Completed by Clinical Unit

Date of Request: _______________

Name of Unit: ____________________ Location of Unit: _______________

Name of Person Submitting Form: ____________________ Contact Number: _______________

Nurse Manager: ____________________ Contact Number: _______________

Medical Director: ____________________ Contact Number: _______________

Effective (date) ________________, we request that the following Point-of-Care Test(s): ____________

__________________________________________________________________________________________

be discontinued on the above mentioned Unit. It is understood that once the Point-of-Care Testing Program Office removes all procedures and associated documentation, all testing by Unit staff will cease.

Nurse Manager’s Signature: ___________________________________________ Date: ____________

Medical Director’s Signature: ___________________________________________ Date: ____________

SECTION B: To Be Completed By Point-of-Care Testing Program Office

Date Request Received: _______________ By: ____________________________

POCT Director’s Signature: ____________________________ Date Approved: _______________

Date Procedures/Logs Removed from Unit: _______________ By: ____________________________

Date Database Updated: _______________ By: ____________________________

Date QC Records Filed: _______________ By: ____________________________

Revision: 3/05