Point-of-Care Testing
New Test Request Form
(One test request per form)

Date: ___________________  Department/Unit Requesting Test: ______________________________

Requester’s Name: ______________________________________      Title: _____________________________

Telephone number / e-mail address: _____________________________________________________________

TEST PROCEDURE: _________________________________________________________

Instrument/Kit Name: _________________________________     Manufacturer: _________________________

A. Test site location(s): ____________________________________________________________ (Building, Floor, Room Number)
   [ ] Inpatients only   [ ] Outpatients only   [ ] Inpatients and Outpatients   [ ] Research Study

B. Hours of operation : ___________________          Frequency of test performance: _____________________

C. CLIA Test Complexity: [ ] Waived [ ] Moderately Complex [ ] Highly Complex [ ] PPM

D. Is this service currently available through the central laboratory? [ ] Yes [ ] No

E. What is the desired turnaround time for this test if performed in the central laboratory?

________________________________________________________________________________________

F. Briefly explain why the current central laboratory services do not fulfill your needs?

________________________________________________________________________________________

________________________________________________________________________________________

G. If this test were made available at the point-of-care, how soon would the results be utilized for clinical decision making?

________________________________________________________________________________________

H. Would patient treatment/management decisions be based solely on the point-of-care test results? [ ] Yes [ ] No

   Explain: ______________________________________________________________________________

   _____________________________________________________________________________________

   _____________________________________________________________________________________
I. Estimate the number of point-of-care tests to be performed: _____/day _____/week ____/month

J. What level(s) of staff would be performing this test and how many would need to be trained?

________________________________________________________________________________________
________________________________________________________________________________________

K. Briefly describe what the patient care benefits/outcomes and potential cost savings would be with implementing this point-of-care test. (Please provide evidence, preferably peer-reviewed, of the test’s clinical utility)

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

L. Are funds approved to support the costs associated with this new test request?  [ ] Yes  [ ] No
(Some costs associated with bringing in POCT include quality control, reagents, test validation, training/competency assessment, proficiency testing, oversight, etc.)

M. Please provide cost center/budget number designated for Point-of-Care Testing costs: ________________

N. Signatures Required:

Medical Director Signature/ Date: _______________________________________________________________

PRINT NAME: _____________________________________________________________________________

Finance Administrator’s Signature/ Date: _________________________________________________________

PRINT NAME: _____________________________________________________________________________

Testing Personnel Manager’s Signature/Date: _____________________________________________________

PRINT NAME: _____________________________________________________________________________

Date Received: ______________________  [ ] Approve  [ ] Disapprove

Director, POCT Program: ____________________________________________________________  Date: __________

Process Completion Date: _________________  Revision: 11/14/11