Research Studies:
Point-of-Care Test Requests

Please provide the following information and return to: The Johns Hopkins Medical Laboratories
Department of Pathology
Point-of-Care Testing Program Office

Mailing Address: CMSC SB-201
600 North Wolfe Street
Baltimore, MD 21287

Fax Number: 410-502-1913

E-mail Address: POCT Group

Name of Study: ______________________________________

Principle Investigator’s Name: ____________________________ Telephone Number: ____________

Study Coordinator’s Name: ______________________________ Telephone Number: ____________

Approximate Length of Study: ____________________________

Study Location: _______________________________________

Please submit copies of your IRB approval and Study Protocol.

Please complete the following Point-of-Care Testing New Test Request Form for each point-of-care test that you wish to perform, i.e., each requested test requires a separate form.
Research Studies:
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: ___________________________________________________________________________________
   _________________________________________________________________________________________
   _________________________________________________________________________________________
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Point-of-Care Testing
New Test Request Form

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 POCT 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