Johns Hopkins Medical Laboratories
Baltimore, Maryland

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