JOHNS HOPKINS
M E D I C I N E

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 address/location: _____
_____

      Inpatients only   Outpatients only   Inpatients and Outpatients

B. Days/Hours of operation: _____   Frequency of test performance: _____

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

D. Are there current CLIA/State licenses for testing for this site?   Yes   No

IF YES	IF NO
Current CLIA #	Name of facility to be listed on the License:
Maryland State License #	Email for facility contact:
Date changes are to occur:	Fed Tax ID Number:

Current test menu:	Type of facility:
	  a. Ambulatory Surgery d. Mobile Lab
	  b. Health Fair e. Independent
	  c. Physician office

	Type of ownership
	  a. Private Nonprofit c. Proprietary
	  b. Other Nonprofit

	Does the director serve as director to other laboratories Yes No If YES, list CLIA #'s:

	Director Must submit the following with application:
	  a. For MD - Medical Diploma, Board Certification and Medical License
	  b. For PhD – Diploma, Board Certification and CV

E. Is this service currently available through the central laboratory?   Yes   No

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

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

_____

_____

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

_____

I. Would patient treatment/management decisions be based solely on the point-of-care test results?   Yes   No
Explain: _____

_____

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

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

_____

L. 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)

_____

_____

_____

M. Are funds approved to support the costs associated with this new test request?   Yes   No

Costs associated with POCT, in addition to the cost of a tests device or kit, may include annual fees for connectivity, quality control, reagents, test validation, training/competency assessment, proficiency testing, oversight, etc.

Description of Charge for Each Test System	Total Cost	Frequency
Laboratory Proficiency Testing		
Depending on amount of tests performed and level of complexity. Total cost to be determined once New Test Request is completed. Proficiency Test Kits	$250 - $450	Annual
Instrument, Reagent, Control Costs		
Instruments, reagents and controls costs will be itemized upon request	$50 - $10,000	Varied
Quality Oversight Fees		
Depending on amount of tests performed and level of complexity. Total cost to be determined once New Test Request is completed.	$200 -$750	Annual
Telcor Connectivity Fees		
Instrumentation that requires connectivity $385 per instrument type (if 2 instrument types, $385 x 2)	$385	Annual

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

O. Signatures Required:

Medical Director Signature/ Date: _____

PRINT NAME: _____

Finance Administrator's Signature/ Date: _____

PRINT NAME: _____

Testing Personnel Manager's Signature/Date: _____

PRINT NAME: _____

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Date POCT Received: _____

Director Date: _____   Approve   Disapprove

Signature Director, POCT Program: _____

Date Submitted to CQI for Billing/Licensing: _____   Needs Telcor: Yes: $_____ No

Revision 10/2019