Point of Care (POC): New/Replacement Test Application Form

Point of Care testing is defined as testing performed outside a central lab environment, near or at the patient bed side/site. The C&W Laboratory is responsible for the governance, oversight, operation and quality of all Point of Care Testing at CW. Any request for POCT testing, new or modified, must be evaluated and approved by appropriate Medical and Operations Staff.

Instructions:
Please complete this form and email to: POCTLab@cw.bc.ca

Principal applicant to complete Sections A through E below.
Grey areas Laboratory use only.

See the POCT-new Program Flows power point. Upon review of this document, the applicant will be required to meet with the hospital POCT Committee and/or POCT working group to review application, the outcome, provide further details and as needed.

Section A: GENERAL INFORMATION

Date	Clinical Area Requesting POCT
Clinical Area Medical Lead	Email/contact
Clinical Area Operations Leader or Designate	Email/contact
End User Representative:	
Relevant Pathology Area:	

Section B: POC TEST REQUEST

Test description:	
Current method of test delivery: ☐ Laboratory ☐ Point of Care - same instrument (requesting additional or replacement unit) ☐ Point of Care - different instrument (please specify):	
Current average lab turn around time from collection to result:	
Current Test volume per month	Current Test volume per day
Brief explanation how current method is not satisfying testing needs	
Purpose of Test:)	

☐ Screen ☐ Monitor ☐ Diagnose ☐ Rule in/Rule out disease
List essential characteristics this POC test/device needs to have:
Note: A separate attachment may be used to describe the POC test proposal and justification for the request, if needed.

Section C: BUDGET ESTIMATE (subject to laboratory review)
Blurb to prompt consideration of these costs.

Capital Equipment Cost:			Per device
Number of devices requested:			
Material Costs: (variable)			
Reagents	$		Per test
Consumables	$		Per Test
Quality Control material	$		Per day of testing (incl. all QC levels)
Proficiency Testing Program	$		Per year (min. 2 PT events)
Labour Costs: can we put a minimum cost here to guarantee recovery. Add VALIDATION costs (these are fixed costs)			
Training	$	Hours	
Patient/QC/PT testing	$	Minutes	Per test (include prep, result recording etc.)
Funding:			
Source:			
Status:	☐ In place	☐ Applied for	☐ Unfunded
Program BU, Site and Department:			

Total cost per test:

To be compared to existing cost and/or cost of central lab testing.
The funding for the above is the responsibility of the requesting Program and Lab must have ordering access or Financial Signing Register (FSR) to the Program's cost center.

Section D: SCOPE OF INTENDED USE

Patient Population	# of patients per year	# of Tests per unit time
Inpatient:		
Outpatient:		
Clinical area(s) involved in use of instrument and/or results:		
Proposed operator group(s):		
Total number of operators:		
Describe how POC test results will be documented and reported:		
Describe the benefits of this POC test brings to the hospital; provide supporting data:		
Describe the benefits this POC test brings to patients; provide supporting data:		

Pathology Review of application

Test description	Comments:
Device(s) proposed	Comments:
Scope of use	Comments:
Data management	Comments:
Budget estimate	Comments:

Preliminary Pathology Summary / Impact Assessment:

Clinical applicability:

Analytical Performance:

Patient considerations:

Operator group:

Cost Assessment (evaluation, implement device & ongoing QA management):

Alternate proposal or proceed with laboratory evaluation/ implementation:

Proposed Evaluation Plan

Device(s) (consider other vendors):

Lab component:

Clinical component:

Time frame: Date: Duration:

Cost Laboratory program:

Vendor(s):

Clinical Area:

Signature (Clinical Head)_____ (date) (name)

(Program Manager) _____ (date) (name)