Appendix E

POCT REQUEST FORM

REQUEST FOR APPROVAL OF NEW POINT OF CARE TEST OR DEVICE

All point of care in-vitro laboratory testing must be evaluated and approved by the POCT Committee to ensure that it meets institutional goals as well as state and federal regulations. To expedite your request, please complete all information below. Please attach all pertinent documents to this form and submit to: POCT Committee, Attn: Cynthia Ishizaki, UCSF Clinical Lab Box 0100, or FAX 514-6841.

Date request submitted: ___________

1. Test requested: __________________________________________________________

2. Name(s) of device(s): ____________________________________________________

3. How did you learn about this test?
   [ ] Contacted by vendor(s) (Company & name): _____________________________
   [ ] Journal article (Citation): _____________________________________________
   [ ] Conference (name of conference and date): _____________________________
   [ ] Recommended by colleague (name, institution and phone #): _____________

4. Purpose for introducing test
   [ ] Patient care goals. Explain: __________________________________________
   [ ] Provides greater benefit than current system. Explain: ___________________
   [ ] Rapid result (< 30-60 min) improves patient care or reduces cost. Explain:  
     ______________________________________________________________________
   [ ] Test not currently provided by this institution.
   [ ] New technology
   [ ] Replacement for (test) , or (instrument) Describe: ________________________

5. Proposed Measurable outcomes (e.g. based on #4 what would be the measurable outcomes goals and is there baseline data?)
   Outcome Goal #1: _________________________________________________________
   ________________________________________________________________
   Outcome Goal #2: _________________________________________________________
Outcome Goal #3: ____________________________________________________________________________

6. Where will this test be used? (List patient population, nursing units and/or departments):
______________________________________________________________________________
______________________________________________________________________________

7. Estimate annual test volume: _____________________

8. Estimate of annual cost: ________________________

9. Personnel
   Estimate of number of potential users: __________
   Job categories of potential users: ______________________________________________________________________

10. Name of requestor: (Title, Department, Phone #, Pager #, e-mail):
______________________________________________________________________________
______________________________________________________________________________

11. Name of contact person (Title, Department, Phone #, Pager #, e-mail):
______________________________________________________________________________
______________________________________________________________________________