# Request for New Point of Care Test (POCT)

**Complete all areas**

Submit to Chair, POCT Testing Committee, c/o Director, SFGH Clinical Laboratory, 2M14 SFGH
Questions? Call 206-8588

<table>
<thead>
<tr>
<th>Request (CHN ID#):</th>
<th>POCT location:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone:</td>
<td>Clinical Service/Department:</td>
</tr>
<tr>
<td>FAX:</td>
<td></td>
</tr>
<tr>
<td>Pager:</td>
<td>Cost center account #:</td>
</tr>
</tbody>
</table>

**Test name:** ____________________________  **Specimen type:** ____________________________

**Test indications** (explain; use back of sheet if necessary)

- [ ] Diagnosis:

- [ ] Monitoring:

**Anticipated test volume:** _______/day  _______/week  _______/month

**Is this test currently offered by the SFGH Clinical Laboratory?**  [ ] Yes**  [ ] No

**If YES, why is “Point of Care” service necessary?**

**Product information:** Please attach product brochure/package insert and contact information (telephone, pager, and/or FAX #) for the manufacturer’s representative.

- **Cost of instrument:** 
  - **Cost for instrument maintenance (including service contract):**
  - **Cost of reagent/test:**
  - **Cost of control materials:**
    - Number of levels for control materials:
    - Frequency at which controls must be run:

- **Does the instrument store test results electronically?**  [ ] Yes  [ ] No

- **Interface capability for Laboratory Information System(s)?**  [ ] Yes  [ ] No

**I agree to:**

- Purchase instrument, reagents, and necessary control materials.
- Follow testing policies and procedures developed by the SFGH Clinical Laboratory.
- Maintain a subscription to the relevant proficiency test program.
- Develop a policy and procedure for my individual clinic/practice/service for:
  - when tests will be performed.
  - how test results will be recorded.
  - what clinical actions will be taken based on the test result.
- Maintain and have available for inspection at any time records of training, competency and proficiency for all testing personnel.

**Contact person:**

<table>
<thead>
<tr>
<th>Telephone:</th>
<th>Fax:</th>
<th>Pager:</th>
</tr>
</thead>
</table>

**Signatures (required)** | **Printed name:** | **Date:**

<table>
<thead>
<tr>
<th>Requestor:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Chief/Director:</td>
<td></td>
</tr>
<tr>
<td>Administrator:</td>
<td></td>
</tr>
<tr>
<td>Associate Administrator:</td>
<td></td>
</tr>
</tbody>
</table>