

University of Colorado Hospital - Clinical Laboratory
Point of Care Testing Program

For POCC use only
 Ticket Number _____
 Application Receiving
 Date: _____

Request for Testing (New, Additional or Change in Testing Methodology)

Instructions:

Complete fields #1- #10 of this form. Attach required documentation. Submit to Point of Care Testing Coordinator (POCC); campus box A022, Fax #2-0382 or deliver to CC 038.

1. Requesting site _____ Application Date _____

2. Contact person _____ Phone number _____ Fax #: _____

3. Test requested : _____

Is this a currently approved and available POC test? _____

Is this a new POC test requiring approval? _____

4. Type of specimen to be used

- blood (specify fingerstick or venipuncture)
- urine
- tissue, specify _____
- other _____

5. Reason for doing this test

- clinic located in off-site location that does not have UH Lab services
- lab cannot meet needs, specify _____
- _____
- lab does not offer test
- other, specify _____

6. Test Priority

Please answer the following questions:	Yes	No
Is your clinic/unit care for High Risk patients ?		
Is this test critical for medication adjustment?		
Are you going to performed 20 test or more per week?		
Is this test currently included in the POCT program menu?		

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7. Funding

Is a capital purchase of equipment needed to do this test? Yes No

If equipment is capital, state source of funding _____

List staff who will be doing this test, determine number of CNA/MAs and RNs who will be doing testing _____

8. Cost of training and competency for staff who will be doing this test

Initial Training (required for all testing staff)
_____ Number CNA/MAs x \$.17 per minute x 60 minutes \$ _____
_____ Number of RNs x \$.42 per minute x 60 minutes \$ _____

Competency Verification (cost per year for waived test)
_____ Number of NA/MAs x \$.17 per minute x 30 minutes \$ _____
_____ Number of RNs x \$.42 per minute x 30 minutes \$ _____

For moderately complex tests - add training verification at 6 months
_____ Number of NA/MAs x \$.17 per minute x 30 minutes \$ _____
_____ Number of RNs x \$.42 per minute x 30 minutes \$ _____

9. Cost to acquire appropriate CLIA registration

Types of CLIA Licenses: Waived, Provider Performed Microscopy or Certificate of Accreditation

If you already have a CLIA License and are maintaining the same testing level write N/A as your cost.

An upgrade in CLIA certificate requires a submission form to the Colorado CLIA office.. Call POCT office for assistance.

Contact Colorado CLIA at (303) 692-3295 for current form \$ _____

Attach a current copy of your site current CLIA certificate.

10. Is a service agreement going to be purchased? No Yes If yes, the cost is: \$ _____

Signature: _____
Practice Manager/Nurse Manager /Date

Signature : _____
Medical Director/Practice Director / Date

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The following information is to be completed after the POCT Committee has approved the appropriate vendor. POCT office will complete this section.

11. Priority score : _____

12. Cost of doing this test at site

- Cost per test: (cost for each cartridge, dipstick, etc.) \$ _____
- Equipment: \$ _____
- Reagents (Strips, Device kits, maintenance supplies, if applicable)
Controls: Liquid controls (Note: **Generally**, 2 levels of controls
are to be run each shift or day of operation.) \$ _____
- Electronic QC device, (if applicable) \$ _____

13. Maintenance

Cost of instrument maintenance, if applicable, \$ _____

Specify who will be responsible for doing maintenance _____

Was maintenance (like semi-annual Preventive Maintenance) included in the contract? Yes No

Cost of proficiency testing, if applicable (attach quote from vendor) \$ _____

Subscriptions to the Proficiency Testing program are “renew” every year, during the fall. This includes an annual registration fee.

Please, remember to include this cost during budget preparation. (For budget calculations, we **estimate** a 5% increase in cost annually.)

Practice Manager/Nurse Manager Date

Medical Director/Practice Director Date

Note: These signatures are mandatory.

