UC Davis Health Pathology and Laboratory New Test/Product/Process Request Form

INSTRUCTIONS

The Department of Pathology and Laboratory Medicine approves all new *in vitro* diagnostic tests and blood products used at UC Davis Health. This includes tests performed at the facility, products under transfusion services, as well as tests performed at referral facilities (*i.e.,* send outs), and point-of-care testing. Requests are reviewed by Pathology and Laboratory Medicine. Additional review may be required via the hospital Laboratory Test Utilization Committee. Please fill out the form and address all items.

A. REQUESTING PROVIDER / SERVICE / CONTACT

Requesting Provider:

Hospital Department / Division:

Email:	Phone#:

B. TEST/PRODUCT CATEGORY

New Test/Product Name:

Pathology (*e.g.,* tissue histology, etc)
Laboratory Medicine (e.g., Chemistry, Hematology, Molecular, etc)
Transfusion Medicine
Point-of-Care Testing (if selected, please provide cost center:_______________)
Send Out (if selected, please provide vendor name and contact:________________________)

Test/Product Utilization:

Demographic (check all that apply): Inpatient Outpatient Emergency Department
Clinical Trials / Research: New tests/products/processes for research must also complete the Pathology Clinical Research Oversight Committee (CROC) intake form:
https://ctscassist.ucdmc.ucdavis.edu/ctscassist/surveys/?s=TFTKKYMTFM

Anticipated Number of Tests/Products Used Per Day: ____________

Estimated Cost / Reimbursement for New Test Request: ___________

C. SITUATION, BACKGROUND, ASSESSMENT, RECOMMENDATION (SBAR)

Please provide justifications for the new test or product using the “SBAR” format. Note: Requests for alternative tests/products that are either available in-house or through an existing approved referral laboratory require inclusion of clinical and analytical data (*i.e.,* literature) explaining why one method is better than another.

SITUATION
BACKGROUND
ASSESSMENT
RECOMMENDATION

REQUESTING DEPARTMENT CHAIR / DIVISION CHIEF APPROVAL

Signature: _______________________Print Name: ____________________Date: _________

PATHOLOGY USE ONLY

Primary Laboratory Section:		Other(?):
Section Supervisor / Manager:		
Status: Approved Not Approved		
Section Medical Director:		