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). For point of care (POC) test, use New POC Test Request Form. 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. Requestor email this completed form to hs-newlabtest@ucdavis.edu.

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
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.

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:

Adopted 03/2020 Revised 04/2021