## UC Davis Health Pathology and Laboratory

# New Point-of-Care (POC)Test Request Form

**INSTRUCTIONS**

The Department of Pathology and Laboratory Medicine approves all new *in vitro* diagnostic tests including point-of-care tests at UC Davis Health. Requests are reviewed by Pathology and Laboratory Medicine. Additional review is 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 POC Test/Product Name:**

Manufacturer:

CLIA Complexity: □ Waived □ Moderate

Intended Users:

User Education Level:

Location for Testing (provide exact location at your facility):

IT Requirements (does device have means to connect to EMR):_____YES _____ NO

Anticipated No. of Tests used per Day/Month/Year:

Estimated Cost/Reimbursement for New Test Request:

**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 ClinicalResearch Oversight Committee (CROC) intake form: https://ctscassist.ucdmc.ucdavis.edu/ctscassist/surveys/?s=TFTKKYMTFM

**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:_____

**REVENUE INTEGRITY PROGRAM REVIEW/APPROVAL**

Signature:_____Print Name:_____Date: _____

**PATHOLOGY USE ONLY**

| | |
|---|---|
| Primary Laboratory Section: | Other(?): |
| Section Supervisor / Manager: | |

Status: □ Approved □ Not Approved

Section Medical Director: