UNC HEALTH CARE
McLendon Clinical laboratories

Point-of-Care Testing
New Test Request Form
(Submit one form per test)

All point-of-care *in vitro* testing must be evaluated and approved by the POCT Committee to ensure that it meets institutional goals as well as state and federal regulations. To expedite your request, please complete all information below and submit to: POCT Committee via poc@unch.unc.edu

Date:	Department Requesting Test:
Requester's Name:	Title:
Phone # / Email:	
Test requested:	
Instrument/Kit Name (If known):	Manufacturer (If known):
How did you learn about this point-of-care test? (e.g. vendor, literature, conference, colleague)	

Testing site location(s):	(i.e. Facility, Floor/Unit)
Testing population:	(i.e. Inpatient, outpatient, research)

Briefly describe what the patient care benefits/outcomes and potential cost savings would be with implementing this point-of-care test. (Please provide peer-reviewed evidence, if available, of test's clinical utility in select clinical setting)

Would patient treatment/management decisions be based solely on the point-of-care test results?
[ ] Yes [ ] No Please explain:

Estimated weekly point-of-care test volume:
Estimated # of potential point-of-care test operators:
Indicate the classifications of potential point-of-care test operators:

The following names and approval are required prior to new test consideration by POCT Committee

Medical Director Name:	Test Request Approved: [ ] Yes [ ] No
Vice President Name:	Test Request Approved: [ ] Yes [ ] No
Testing Personnel Manager's Name:	Test Request Approved: [ ] Yes [ ] No

(To be completed by POC)

Test connectivity: [ ] Manual [ ] Interfaced

Indicate where test results, reference range, analyst, date, time would be recorded:

CLIA Test Complexity: [ ] Waived [ ] Moderate Complexity [ ] Provider Performed Testing (Microscopy)

POCT Committee Review Date:	Test Request Approved: [ ] Yes [ ] No
POCC, Signature:	Date:
Director, POC Signature:	Date: