Point-of-Care Testing Request Form

Date of Request (mm/dd/yy):

Name of Requestor:

Contact Phone Number:

Department:

Cost Center:

Dept VP (Need Signature):

Does your department have funding for this request?

☐ Yes ☐ No

How quickly do you wish to implement this request?

What is the current Turn Around Time from the main lab?

Please explain why you think adding Point-of-Care Testing would be beneficial to your department.

In the section below, place a check mark next to the Point of Care Testing that you would like to add. Please indicate the estimated annual volume next to each of the chosen tests.

√	**Point of Care Testing Menu**	Volume
	Whole Blood Chemistries	
	Blood Gases, w/Lytes, H&H, Lactate	
	Prothrombin time with INR	
	Glucose	
	Hemoglobin (measured)	
	Hemoglobin A1C	
	Urine dip	
	Urine Pregnancy Screen	
	Strep A Antigen	
	Influenza A & B Antigen	
	Coronavirus	

√	**Point of Care Testing Menu**	Volume
	HIV Antibodies	
	Urine Drug Screen	
	Other:	

# of Testing Personnel to be trained:

Send completed form to: pmhpoct@phhs.org

The following information will be completed by the Point-of-Care staff and will be returned to you prior to submission to the Point of Care Steering Committee.

Instrument costs:

IT Costs:

Regulatory Costs:

Reagent/Supply Costs

Estimated 1st Yr Costs: