POCC #	POCT-	Date Received		Date Tabled at POCC	

Point-of-Care Testing (PoCT) Submission Form

All Point-of-Care Testing devices that require PathWest support are to be submitted for review and approval by the PathWest Clinical and Scientific Governance Committee (CSGC) and the Designated Person using this form in accordance with the PathWest Point-of-Care Testing Policy (POL-249). Additional information relevant to the application should be submitted at the same time. **Please use a separate submission form for different sites.**

Please return this form to: PoCT Department, PathWest, QEII Medical Centre, Nedlands, WA (poct.pathwest@health.wa.gov.au)

Applicant Name:		**Date:**
Position / Title:		**Phone:**
Email address:		
Ward or Department:		
Hospital:		
Area Health Site:		
Point-of-Care Tests Required :		

Type of submission	☐	**New Submission**	☐	**Amend/Change Submission**

This submission must be approved and signed by the appropriate Clinical Managers

Clinical / Unit Manager:	Name: Signature/HE number:	Date Phone:	
Business / Ops Manager:	Name: Signature/HE number:	Date Phone:	
Supervising PathWest Medical Scientist in Charge:	Name: Signature/HE number:	Date Phone:	

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Have you read the PathWest Point-of-Care Testing Policy (POL-249)?	☐ YES	☐ NO
Is this PoCT proposal compliant with all policy requirements?	☐ YES	☐ NO*
* If NO, please indicate the area(s) of the policy this proposal is not compliant with:		
Describe the type of PoC testing to be introduced or expanded:		
Describe why PoCT is being introduced or expanded. **Indicate the anticipated benefits of testing closer to the patient.** **How will these be measured?** **Will PoC testing be in addition to laboratory testing available on site?**		
Who is your target patient population for PoC testing?		

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Approximately how many <u>patients</u> will be tested by the PoCT device per week?					
1 – 5 ☐	5 – 10 ☐	10 – 20 ☐	20 – 50 ☐	50 – 100 ☐	100+ ☐
Approximately how many <u>tests</u> will be done on the PoCT device per week?					
1 – 5 ☐	5 – 10 ☐	10 – 20 ☐	20 – 50 ☐	50 – 100 ☐	100+ ☐
Approximately how many <u>individuals</u> will perform the Point-of-Care testing?					
1 – 5 ☐	5 – 10 ☐	10 – 20 ☐	20 – 50 ☐	50 – 100 ☐	100+ ☐

Who will perform the Point-of-Care Testing?		
Medical Staff:	☐ YES	☐ NO
Nursing Staff:	☐ YES	☐ NO
Technicians:	☐ YES	☐ NO
Other *(please specify):* e.g. PathWest staff		
Who will be responsible for: • **ongoing quality control checks and device maintenance** • **training staff to use the PoCT device and retaining training records** • **ongoing compliance with the PoCT policy**		
Hospital Staff (e.g. Nurse Educator):	☐ YES	☐ NO
PathWest Laboratory Staff:	☐ YES	☐ NO
Other *(please specify)*:		

Costs associated with introducing or expanding PoCT:	
Estimated cost of requested PoCT device(s): (Include purchase cost of the device, freight and commissioning)	$
Cost of associated items (as relevant):	
☐ Annual cost of consumables $	☐ Quality Control $
☐ Other costs: (please attach relevant documentation)	

How will the PoCT results be recorded? (tick all relevant options)
• Recorded in the patient notes: ☐
• Stored electronically on the device: ☐
• Electronically downloaded/transferred to PathWest LIS & iSoft Clinical Manager ☐

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PathWest Principal Scientist (GX lab):		
Name:		Date:
Signature:		

- DMC Endorsement -		
The submission has been:	☐ Endorsed	☐ NOT Endorsed
Reason(s) if not endorsed:		
POCT Instrument/s & Tests endorsed:		

Chair DMC:		
Name:		Date:
Signature:		

PathWest Designated Person:		
Name:		Date:
Signature:		

Notifications: Return to PathWest POC (poct.pathwest@health.wa.gov.au) for action		
	Applicant	Laboratory MSIC
Who was notified:		
By whom:		
Date:		