



DIAGNOSTIC ACCREDITATION PROGRAM
College of Physicians and Surgeons of British Columbia

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Facility Information for Initial Assessment

DIAGNOSTIC IMAGING – COMMUNITY

FACILITY INFORMATION

Diagnostic imaging service name: _____

Address: _____

Phone number: _____ Projected date of facility opening or discipline starting: _____

NEW MODALITIES TO BE ACCREDITED (Check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Radiology | <input type="checkbox"/> Mammography |
| <input type="checkbox"/> Ultrasound | <input type="checkbox"/> Echocardiography |
| <input type="checkbox"/> Computed tomography | <input type="checkbox"/> Magnetic resonance imaging |
| <input type="checkbox"/> Nuclear medicine | <input type="checkbox"/> Bone densitometry |

CONTACT PERSON FOR IMAGING SERVICE ACCREDITATION ACTIVITIES

Name: _____ Title: _____

Address: _____

City: _____ Province: _____ Postal code: _____

Phone number: _____ Fax number: _____

Cell phone number: _____ Email address: _____

ORGANIZATIONAL CHART

- Imaging service organizational chart attached.

LEADERSHIP

Medical leader

Name: _____ Title: _____

Email address: _____ Location: _____

Administrative leader

Name: _____ Title: _____

Email address: _____ Location: _____

Facility Information for Initial Assessment *continued*

LEADERSHIP

Technical leader (e.g. chief technologist/manager)

Name: _____ Title: _____

Email address: _____ Location: _____

Other individuals appointed to leadership positions (e.g. professional practice leader)

Name: _____ Title: _____

Email address: _____ Location: _____

INTERPRETING PHYSICIANS BY MODALITY

Name: _____ CPSID: _____

Modality: Radiology Mammography Ultrasound Echocardiography
 CT MRI Nuclear medicine BMD

Location: On-site Off-site – specify location: _____

Name: _____ CPSID: _____

Modality: Radiology Mammography Ultrasound Echocardiography
 CT MRI Nuclear medicine BMD

Location: On-site Off-site – specify location: _____

Name: _____ CPSID: _____

Modality: Radiology Mammography Ultrasound Echocardiography
 CT MRI Nuclear medicine BMD

Location: On-site Off-site – specify location: _____

Name: _____ CPSID: _____

Modality: Radiology Mammography Ultrasound Echocardiography
 CT MRI Nuclear medicine BMD

Location: On-site Off-site – specify location: _____

Facility Information for Initial Assessment *continued*

INTERPRETING PHYSICIANS BY MODALITY			
Name: _____		CPSID: _____	
Modality: <input type="checkbox"/> Radiology	<input type="checkbox"/> Mammography	<input type="checkbox"/> Ultrasound	<input type="checkbox"/> Echocardiography
<input type="checkbox"/> CT	<input type="checkbox"/> MRI	<input type="checkbox"/> Nuclear medicine	<input type="checkbox"/> BMD
Location: <input type="radio"/> On-site		<input type="radio"/> Off-site – specify location: _____	
Name: _____		CPSID: _____	
Modality: <input type="checkbox"/> Radiology	<input type="checkbox"/> Mammography	<input type="checkbox"/> Ultrasound	<input type="checkbox"/> Echocardiography
<input type="checkbox"/> CT	<input type="checkbox"/> MRI	<input type="checkbox"/> Nuclear medicine	<input type="checkbox"/> BMD
Location: <input type="radio"/> On-site		<input type="radio"/> Off-site – specify location: _____	
Name: _____		CPSID: _____	
Modality: <input type="checkbox"/> Radiology	<input type="checkbox"/> Mammography	<input type="checkbox"/> Ultrasound	<input type="checkbox"/> Echocardiography
<input type="checkbox"/> CT	<input type="checkbox"/> MRI	<input type="checkbox"/> Nuclear medicine	<input type="checkbox"/> BMD
Location: <input type="radio"/> On-site		<input type="radio"/> Off-site – specify location: _____	

Facility Information for Initial Assessment *continued*

DIAGNOSTIC RADIOLOGY

Modality not applicable

Number of technical staff (FTE): _____

Staff members are:

CAMRT certified or are eligible to write the CAMRT certification examination

Combined laboratory X-ray technologists (CLXT)

Neither—please provide name(s) and qualifications:

Name: _____ Qualifications: _____

Name: _____ Qualifications: _____

Name: _____ Qualifications: _____

Is there a dedicated supervisor for this area? Yes No

If yes, please provide name and title: _____

Days and hours of operation: _____

Are on-call service provided? Yes No

Approximate number of examinations performed daily: _____

Approximate number of examinations performed annually: _____

Are pediatric examinations performed? Yes No

Scope of services

Radiography Not applicable

Number of imaging rooms: _____ Type of imaging systems: Film-screen Digital

Are portable examinations performed? Yes No

If yes, please indicate in what areas: _____

Is IV contrast administered? Yes No

Are medications administered? Yes No

If yes, please list the medications: _____

Fluoroscopy Not applicable

Number of imaging rooms: _____

Facility Information for Initial Assessment *continued*

DIAGNOSTIC RADIOLOGY

Performance of:

- GI/GU
- Diagnostic angiography
- Invasive/interventional procedures
- Other routine diagnostic fluoroscopy examinations

Please list examinations: _____

Are there dedicated days when fluoroscopy procedures are performed? Yes No

If yes, please explain: _____

Methods of sedation: N/A Mild (oral) Conscious sedation or general anesthesia

Equipment list

Included: Recent radiation protection surveys for all radiographic and radioscopy rooms. Yes No

Who is responsible for the maintenance of diagnostic equipment? _____

Radiography units

Make and type (e.g. film-screen, CR, DR)	Model	Year	Location (e.g. room number)

Radiography mobile units

Make and type (e.g. film-screen, CR, DR)	Model	Year	Location (e.g. room number)

Fluoroscopy units

Make and type (e.g. film-screen, CR, DR)	Model	Year	Location (e.g. room number)

Facility Information for Initial Assessment *continued*

DIAGNOSTIC RADIOLOGY			
C-arms			
Make and type (e.g. film-screen, CR, DR)	Model	Year	Location (e.g. room number)
_____	_____	_____	_____
_____	_____	_____	_____
Film processors			
Make and type (e.g. film-screen, CR, DR)	Model	Year	Location (e.g. room number)
_____	_____	_____	_____
Film digitizers			
Make and type (e.g. film-screen, CR, DR)	Model	Year	Location (e.g. room number)
_____	_____	_____	_____
Film printers			
Make and type (e.g. film-screen, CR, DR)	Model	Year	Location (e.g. room number)
_____	_____	_____	_____

Facility Information for Initial Assessment *continued*

DIAGNOSTIC MAMMOGRAPHY

Modality not applicable

Number of technical staff (FTE): _____

Other staff (e.g. technologist assistants, etc.): _____

Staff members are CAMRT certified and have specialized training in mammography: Yes No

If no, please provide name(s) and qualifications:

Name: _____ Qualifications: _____

Name: _____ Qualifications: _____

Name: _____ Qualifications: _____

Is there a dedicated supervisor for this area? Yes No

If yes, please provide name and title: _____

Days and hours of operation: _____

Approximate number of diagnostic mammography examinations performed daily: _____

Approximate number of diagnostic mammography examinations performed annually: _____

Number of imaging rooms: _____

Scope of services

Type of imaging systems: Film-screen Digital

Performance of:

Screening mammography (SMPBC)*

Diagnostic mammography

Specimen radiography

Stereotactic core biopsy

Fine needle aspiration

Needle-wire localization

Cyst aspiration

Other: _____

*Screening mammography is not accredited by the Diagnostic Accreditation Program.

Approximate number of invasive breast procedures performed either daily, weekly or monthly: _____

Are there dedicated days when breast procedures are performed? Yes No N/A

If yes, please explain: _____

Are medications administered? Yes No

If yes, please list the medications: _____

Facility Information for Initial Assessment *continued*

DIAGNOSTIC MAMMOGRAPHY			
Equipment list			
Included: Recent radiation protection surveys for all mammography rooms.		<input type="radio"/> Yes	<input type="radio"/> No
Included: Recent medical physicist reports for each mammography unit.		<input type="radio"/> Yes	<input type="radio"/> No
Who is responsible for the maintenance of diagnostic equipment? _____			
Mammography units			
Make and type (e.g. film-screen, CR, DR)	Model	Year	Location (e.g. room number)
_____	_____	_____	_____
_____	_____	_____	_____
Film processors			
Make and type (e.g. film-screen, CR, DR)	Model	Year	Location (e.g. room number)
_____	_____	_____	_____
Film digitizers			
Make and type (e.g. film-screen, CR, DR)	Model	Year	Location (e.g. room number)
_____	_____	_____	_____
Film printers			
Make and type (e.g. film-screen, CR, DR)	Model	Year	Location (e.g. room number)
_____	_____	_____	_____

Facility Information for Initial Assessment *continued*

DIAGNOSTIC ULTRASOUND

Modality not applicable

Number of technical staff (FTE): _____

Staff members are:

- ARDMS certified or are eligible to write the ARDMS certification examination
- Sonography Canada certified or are eligible to write the Sonography Canada certification examination
- Neither—please provide name(s) and qualifications:

Name: _____ Qualifications: _____

Name: _____ Qualifications: _____

Name: _____ Qualifications: _____

Is there a dedicated supervisor for this area? Yes No

If yes, please provide name and title: _____

Days and hours of operation: _____

Are on-call service provided? Yes No

Approximate number of examinations performed daily: _____

Approximate number of examinations performed annually: _____

Number of imaging rooms: _____

Location and/or room number for endocavity probe disinfection: _____

Scope of services

Performance of:

- Guided Amniocenteses
- Obstetrical B-Scans
- B-Scan IUD localization
- Pelvic B-Scan
- Thorax B-Scan
- Renal B-Scan
- Guided Thoracentesis
- B-Scan Brain
- Extremity B-Scan
- Prostate scan using rectal probe
- Endovaginal Scan
- Breast Sonogram
- Chorionic villus sampling for ultrasonic guidance

Facility Information for Initial Assessment *continued*

DIAGNOSTIC ULTRASOUND

- Nuchal Translucency ultrasound
- Vascular ultrasound
- Miscellaneous ultrasound
- Guidance for biopsy or cyst puncture

Please list procedures performed: _____

Are there dedicated days when procedures are performed? Yes No

If yes, please explain: _____

Other: _____

Methods of sedation: N/A Mild (oral) Conscious sedation or general anesthesia

Are medications administered? Yes No

If yes, please list the medications: _____

Equipment list

Who is responsible for the maintenance of diagnostic equipment? _____

Ultrasound units

Make and type (e.g. film-screen, CR, DR)	Model	Year	Location (e.g. room number)

Facility Information for Initial Assessment *continued*

DIAGNOSTIC ECHOCARDIOGRAPHY

Modality not applicable

Number of technical staff (FTE): _____

Staff members are:

- ARDMS certified in Adult or Pediatric Echocardiography
- Sonography Canada certified in Adult or Pediatric Echocardiography
- Neither—please provide name(s) and qualifications:

Name: _____ Qualifications: _____

Name: _____ Qualifications: _____

Name: _____ Qualifications: _____

Is there a dedicated supervisor for this area? Yes No

If yes, please provide name and title: _____

Days and hours of operation: _____

Are on-call service provided? Yes No

Approximate number of examinations performed daily: _____

Approximate number of examinations performed annually: _____

Number of imaging rooms: _____

Scope of services

Performance of:

- Transthoracic echocardiography (TTE)
- Guided pericardiocentesis
- Exercise echocardiography

If yes, location (e.g. department and room number) of exercise equipment: _____

- Pharmacologic stress echocardiography
- Transesophageal echocardiography (TEE)
- Contrast examinations (e.g. albumin shell microbubbles or agitated saline)
- Other: _____

Are medications administered? Yes No

If yes, please list the medications: _____

TTE Not applicable

Are pediatric examinations performed? Yes No

TEE Not applicable

Facility Information for Initial Assessment *continued*

DIAGNOSTIC ECHOCARDIOGRAPHY			
Are pediatric examinations performed? <input type="radio"/> Yes <input type="radio"/> No			
Location and room number(s) where TEE is performed: _____			
Are there dedicated days when TEE is performed? <input type="radio"/> Yes <input type="radio"/> No			
If yes, please explain: _____			
Location and/or room number for TEE probe disinfection: _____			
Methods of sedation: <input type="checkbox"/> N/A <input type="checkbox"/> Mild (oral) <input type="checkbox"/> Conscious sedation or general anesthesia			
Equipment list			
Who is responsible for the maintenance of diagnostic equipment? _____			
Echocardiography units			
Make and type (e.g. film-screen, CR, DR)	Model	Year	Location (e.g. room number)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Facility Information for Initial Assessment *continued*

DIAGNOSTIC COMPUTED TOMOGRAPHY

Modality not applicable

Number of technical staff (FTE): _____

Other staff (e.g. technologist assistants, dedicated radiology nurses, etc.): _____

Staff members are CAMRT certified and have specialized training in computed tomography: Yes No

If no, please provide name(s) and qualifications:

Name: _____ Qualifications: _____

Name: _____ Qualifications: _____

Name: _____ Qualifications: _____

Is there a dedicated supervisor for this area? Yes No

If yes, please provide name and title: _____

Days and hours of operation: _____

Are on-call services provided? Yes No

Approximate number of examinations performed daily: _____

Approximate number of examinations performed annually: _____

Scope of services

Performance of:

CT without intravenous contrast

CT with intravenous contrast

CT Colonography

CT guided biopsies/interventional procedures

Please list procedures performed: _____

Are there dedicated days when procedures are performed? Yes No

If yes, please explain: _____

Other: _____

Are pediatric examinations performed? Yes No

Methods of sedation: N/A Mild (oral) Conscious sedation or general anesthesia

Are medications administered? Yes No

If yes, please list the medications: _____

Equipment list

Included: Recent radiation protection surveys for all CT room. Yes No

Who is responsible for the maintenance of diagnostic equipment? _____

Facility Information for Initial Assessment *continued*

DIAGNOSTIC COMPUTED TOMOGRAPHY			
CT scanners			
Make and type (e.g. film-screen, CR, DR)	Model	Year	Location (e.g. room number)

Facility Information for Initial Assessment *continued*

DIAGNOSTIC MAGNETIC RESONANCE IMAGING

Modality not applicable

Number of technical staff (FTE): _____

Other staff (e.g. technologist assistants, dedicated radiology nurses, etc.): _____

Staff members are CAMRT certified in MRI (RTMR): Yes No

If no, please provide name(s) and qualifications:

Name: _____ Qualifications: _____

Name: _____ Qualifications: _____

Name: _____ Qualifications: _____

Is there a dedicated supervisor for this area? Yes No

If yes, please provide name and title: _____

Days and hours of operation: _____

Are on-call services provided? Yes No

Approximate number of examinations performed daily: _____

Approximate number of examinations performed annually: _____

Scope of services

Performance of:

MRI without intravenous contrast

MRI with intravenous contrast

MRI guided biopsies/interventional procedures

Please list procedures performed: _____

Are there dedicated days when procedures are performed? Yes No

If yes, please explain: _____

Other: _____

Are pediatric examinations performed? Yes No

Methods of sedation: N/A Mild (oral) Conscious sedation or general anesthesia

Are medications administered? Yes No

If yes, please list the medications: _____

Facility Information for Initial Assessment *continued*

DIAGNOSTIC MAGNETIC RESONANCE IMAGING			
Equipment list			
Who is responsible for the maintenance of diagnostic equipment? _____			
MRI scanner			
Make and type (e.g. film-screen, CR, DR)	Model	Year	Location (e.g. room number)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Facility Information for Initial Assessment *continued*

DIAGNOSTIC NUCLEAR MEDICINE

Modality not applicable

Number of technical staff (FTE): _____

Staff members are CAMRT certified in Nuclear Medicine (RTNM) or are eligible to write the CAMRT certification examination:

Yes No

If no, please provide name(s) and qualifications:

Name: _____ Qualifications: _____

Name: _____ Qualifications: _____

Name: _____ Qualifications: _____

Is there a dedicated supervisor for this area? Yes No

If yes, please provide name and title: _____

Days and hours of operation: _____

Are on-call service provided? Yes No

Approximate number of examinations performed daily: _____

Approximate number of examinations performed annually: _____

Number of imaging rooms: _____

Do you ship radioactive materials? Yes No

Are radiopharmaceuticals prepared on-site? Yes No

Facility Information for Initial Assessment *continued*

DIAGNOSTIC NUCLEAR MEDICINE

Scope of services

Performance of:

- Brain scans
- Bone scans
- Cardiac Blood Pool Imaging (MUGA)
- Gall Bladder Scans
- Heart Scans
- Liver Scans
- Renal Scans
- Myocardial perfusion imaging
- Thyroid uptake and scan
- Sentinel Node Biopsy Injection
- Labeled WBC study
- Therapy procedures—please list: _____
- Other: _____

Are pediatric examinations performed? Yes No

Are diagnostic CT examinations performed? Yes No

Are there dedicated days when examinations/therapies are performed? Yes No

If yes, please explain: _____

Is exercise stress testing performed? Yes No

If yes, indicate where stress testing is performed: In nuclear medicine In cardiology

Another facility: _____

Are medications administered? Yes No

If yes, please list the medications: _____

Methods of sedation: N/A Mild (oral) Conscious sedation or general anesthesia

Facility Information for Initial Assessment *continued*

DIAGNOSTIC NUCLEAR MEDICINE			
Equipment list			
Who is responsible for the maintenance of diagnostic equipment? _____			
Gamma cameras			
Make	Model	Year	Location (e.g. room number)
SPECT/CT systems			
Make	Model	Year	Location (e.g. room number)

Facility Information for Initial Assessment *continued*

DIAGNOSTIC BONE DENSITOMETRY

Modality not applicable

Number of technical staff (FTE): _____

Staff members are CAMRT certified in Radiology or Nuclear Medicine (RTR or RTNM) or are eligible to write a CAMRT certification examination:

Yes No

If no, please provide name(s) and qualifications:

Name: _____ Qualifications: _____

Name: _____ Qualifications: _____

Name: _____ Qualifications: _____

Is there a dedicated supervisor for this area? Yes No

If yes, please provide name and title: _____

Days and hours of operation: _____

Approximate number of examinations performed daily: _____

Approximate number of examinations performed annually: _____

Equipment list

Who is responsible for the maintenance of diagnostic equipment? _____

DXA units

Make	Model	Year	Location (e.g. room number)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Facility Information for Initial Assessment *continued*

IMAGING INFORMATICS

Indicate system(s) used to collect and disseminate clinical data (e.g. reports and images):

- No computer systems—**no further information required**
- Computer software for patient registration/billing only—**no further information required**
- Information System (e.g. RIS, etc.) and no PACS integration

Manufacturer:

- PACS and no information system integration

Manufacturer:

- Integrated Information System/PACS

Manufacturer(s):

Are there modalities that are not integrated into PACS? Yes No

If yes, list the modalities and how the images are stored (e.g. film): _____

For this facility where are the following located:

Archive servers: _____

Database servers: _____

Who is responsible for system support at this facility (e.g. RIS/PACS Administrators, etc.)?

Name	Title	Location	Contact information
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

EXAMINATION REPORTING AND INTERPRETATION

When is an interpreting physician on-site to interpret examinations:

- All the time
- Only certain days: _____
- Never—explain: _____

Who visits the facility? _____

Frequency of visits: _____

Is any interpretation performed in physician’s homes or off-site offices? Yes No

If yes, indicate locations: _____

Facility Information for Initial Assessment *continued*

EXAMINATION REPORTING AND INTERPRETATION

Are examinations **transmitted to** other facilities for interpretation? Yes No

If yes, please indicate the name of each interpreting physician, location and mode of distribution (e.g. PACS, hard copy print outs couriered):

Name	Location	Mode of distribution
Example: Dr. John Doe	ABC Hospital	Hard copy print outs couriered
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are examinations **received from** other facilities for interpretation? Yes No

If yes, please indicate the name of each interpreting physician, location and mode of distribution (e.g. PACS, hard copy print outs couriered):

Name	Location	Mode of distribution
Example: Dr. John Doe	ABC Hospital	Hard copy print outs couriered
_____	_____	_____
_____	_____	_____
_____	_____	_____

Type of dictation system (e.g. tape, digital, voice recognition): _____

ADDITIONAL HOSPITAL/HEALTH CENTRE INFORMATION

If possible, please provide a diagnostic imaging service floor plan.

Floor plan attached.

Medical director signature: _____ Date: _____

ANY ADDITIONAL INFORMATION YOU WISH TO ADD

If you require additional space, please attach a separate electronic document.

Please return the completed form by email at diagnosticimaging@cpsbc.ca.

The information on this form is collected under the authority of section 5-21 of the Bylaws under the *Health Professions Act*, RSBC 1996, c.183. If you have any questions about the collection and use of this information, please contact the College at 300-669 Howe Street, Vancouver BC V6C 0B4 or by phone at 604-733-7758 or 1-800-461-3008 (toll-free in BC).