DIAGNOSTIC ACCREDITATION PROGRAM

College of Physicians and Surgeons of British Columbia

300–669 Howe Street
Vancouver BC V6C 0B4
www.cpsbc.ca

Telephone: 604-733-7758
Toll Free: 1-800-461-3008 (in BC)
Fax: 604-733-3503

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)

- ☐ Radiology
- ☐ Ultrasound
- ☐ Computed tomography
- ☐ Nuclear medicine
- ☐ Mammography
- ☐ Echocardiography
- ☐ Magnetic resonance imaging
- ☐ 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: ☐ 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*

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 radioscopic 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. ◯ Yes ◯ No

Included: Recent medical physicist reports for each mammography unit. ◯ Yes ◯ 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? ◯ Yes ◯ No

Location and room number(s) where TEE is performed: ____________________

Are there dedicated days when TEE is performed? ◯ Yes ◯ No

If yes, please explain: ____________________

Location and/or room number for TEE probe disinfection: ____________________

Methods of sedation: ☐ N/A ☐ Mild (oral) ☐ 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).