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 – HEALTH AUTHORITY

FACILITY INFORMATION

Hospital/health centre name: _____

Health authority: _____

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
- ☐ Other: _____

Is the diagnostic service mobile (e.g. trailer)? ◯ Yes ◯ No

HOSPITAL/HEALTH CENTRE INFORMATION

Number of beds: _____

Other major services that the hospital/health centre provides: _____

Population of town: _____

Other towns or areas the diagnostic imaging service serves: _____

Are there any distinct patient population demographics? _____

Are there any geographic considerations that affect service delivery? _____

Facility Information for Initial Assessment *continued*

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

Regional imaging service administrative leader

Name: _____ Title: _____

Email address: _____ Location: _____

Regional imaging service medical leader

Name: _____ Title: _____

Email address: _____ Location: _____

Health service area imaging service administrative leader

Name: _____ Title: _____

Email address: _____ Location: _____

Health service area imaging service medical leader

Name: _____ Title: _____

Email address: _____ Location: _____

Administrative leader

Name: _____ Title: _____

Email address: _____ Location: _____

Medical leader of imaging service

Name: _____ Title: _____

Email address: _____ Location: _____

Facility Information for Initial Assessment *continued*

LEADERSHIP

Technical leader imaging service (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: ____________________

Name: ____________________ Title: ____________________

Email address: ____________________ Location: ____________________

Hospital/health centre chief operating officer/administrator

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: __________

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): _____

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

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: _____

Is there a dedicated supervisor for this area? ◯ 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: _____

Facility Information for Initial Assessment *continued*

DIAGNOSTIC RADIOLOGY

Fluoroscopy ☐ Not applicable

Number of imaging rooms: _____

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 mammography examinations performed daily: _____

Approximate number of 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

Facility Information for Initial Assessment *continued*

DIAGNOSTIC ECHOCARDIOGRAPHY

TEE ☐ Not applicable

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: _____

Facility Information for Initial Assessment *continued*

DIAGNOSTIC COMPUTED TOMOGRAPHY

Equipment list

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

Who is responsible for the maintenance of diagnostic equipment? _____

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).