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

NEURODIAGNOSTICS – COMMUNITY

FACILITY INFORMATION

Neurodiagnostic service name: _____

Address: _____

Service phone number: _____ Projected date of facility opening: _____

NEW TEST(S) TO BE ACCREDITED (Check all that apply)

- ☐ Electroencephalography (EEG)
- ☐ Electromyography (EMG)
- ☐ Evoked potentials (EP)
- ☐ Nerve conduction studies (NCS)

CONTACT PERSON FOR NEURODIAGNOSTICS SERVICE ACCREDITATION ACTIVITIES

Name: _____ Title: _____

Address: _____

City: _____ Province: _____ Postal code: _____

Phone number: _____ Fax number: _____

Cell phone number: _____ Email address: _____

MEDICAL OFFICE (Check all that apply)

- ☐ Solo practice
- ☐ Technical
- ☐ Multi-physician
- ☐ Administrative

Facility Information for Initial Assessment *continued*

LEADERSHIP

Medical leader

Name: _____ Title: _____

Email address: _____ Location: _____

Administrative leader

Name: _____ Title: _____

Email address: _____ Location: _____

Technical leader (chief technologist/manager)

Name: _____ Title: _____

Email address: _____ Location: _____

Other individual appointed to leadership position

Name: _____ Title: _____

Email address: _____ Location: _____

Facility Information for Initial Assessment *continued*

INTERPRETING PHYSICIANS

Name: ______________________________ CPSID: __________

Tests interpreting: ☐ EEG ☐ EP ☐ EMG/NCS

Location: ◯ On-site ◯ Off-site – specify location: __________

Name: ______________________________ CPSID: __________

Tests interpreting: ☐ EEG ☐ EP ☐ EMG/NCS

Location: ◯ On-site ◯ Off-site – specify location: __________

Name: ______________________________ CPSID: __________

Tests interpreting: ☐ EEG ☐ EP ☐ EMG/NCS

Location: ◯ On-site ◯ Off-site – specify location: __________

Name: ______________________________ CPSID: __________

Tests interpreting: ☐ EEG ☐ EP ☐ EMG/NCS

Location: ◯ On-site ◯ Off-site – specify location: __________

Name: ______________________________ CPSID: __________

Tests interpreting: ☐ EEG ☐ EP ☐ EMG/NCS

Location: ◯ On-site ◯ Off-site – specify location: __________

Are tests **transferred to** other facilities for interpretation? ◯ Yes ◯ No – explain below:

____

Physician Information:
Physicians intending to provide neurodiagnostics services in the community must submit a credentialing letter confirming that they are credentialed for EMG services. If the physician also performs EMG services within a hospital, the credentialing letter can be requested from the respective health authority. If the physician only works in a private facility, the physician is licensed to their scope of practice through the College of Physicians and Surgeons of BC. For MSP billing purposes for a restricted diagnostic service, the College will review the associated credentials required to be eligible to bill for these services and will notify MSP of the eligibility. For further information please contact credentialing@cpsbc.ca.

Facility Information for Initial Assessment *continued*

ELECTROENCEPHALOGRAPHY (EEG)

☐ *Test not applicable*

Tests performed:

☐ Routine EEG (including awake and asleep recordings)

☐ Portable EEG in critical care areas

☐ Continuous video/EEG recordings (SIU – Seizure investigation unit)

☐ Long-term monitoring in critical care areas

☐ Ambulatory recordings

Number of technologists (FTE): _____

Technologists are: ☐ CAET certified ☐ AETC certified ☐ CBRET certified

☐ ABRET certified ☐ None – specify below:

Name: _____ Qualifications: _____

Name: _____ Qualifications: _____

Name: _____ Qualifications: _____

Is there a dedicated supervisor for this area? ◯ Yes - Specify below: ◯ No

Name: _____ Title: _____

Days and hours of operation: _____

Are on-call services provided? ◯ Yes ◯ No

Approximate number of test performed: Daily _____ Annually _____

EQUIPMENT LIST

Description of equipment: _____

Make: _____ Model/serial number: _____

Year manufactured: _____ Location (e.g. room number): _____

Description of equipment: _____

Make: _____ Model/serial number: _____

Year manufactured: _____ Location (e.g. room number): _____

Description of equipment: _____

Make: _____ Model/serial number: _____

Year manufactured: _____ Location (e.g. room number): _____

Who is responsible for the maintenance of diagnostic equipment? _____

Facility Information for Initial Assessment *continued*

EVOKED POTENTIALS (EP)

☐ *Test not applicable*

Tests performed:

☐ Adult EP

☐ Pediatric EP

☐ Visual EP (VEP)

☐ Brainstem auditory EP (BAEP)

☐ Somatosensory EP (SSEP)

Number of technologists (FTE): _____

Technologists are: ☐ CAET certified ☐ AETC certified ☐ CBRET certified

☐ ABRET certified ☐ None – specify below:

Name: _____ Qualifications: _____

Name: _____ Qualifications: _____

Name: _____ Qualifications: _____

Days and hours of operation: _____

Approximate number of tests performed: Daily _____ Annually _____

EQUIPMENT LIST

Description of equipment: _____

Make: _____ Model/serial number: _____

Year manufactured: _____ Location (e.g. room number): _____

Description of equipment: _____

Make: _____ Model/serial number: _____

Year manufactured: _____ Location (e.g. room number): _____

Description of equipment: _____

Make: _____ Model/serial number: _____

Year manufactured: _____ Location (e.g. room number): _____

Who is responsible for the maintenance of diagnostic equipment? _____

Facility Information for Initial Assessment *continued*

ELECTROMYOGRAPHY (EMG)

☐ *Test not applicable*

Number of technologists (FTE): _____

Technologists are: ☐ CAET certified ☐ AETC certified ☐ CBRET certified

☐ ABRET certified ☐ None – specify below:

Name: _____ Qualifications: _____

Name: _____ Qualifications: _____

Name: _____ Qualifications: _____

Is there a dedicated supervisor for this area? ◯ Yes - Specify below: ◯ No

Name: _____ Title: _____

Days and hours of operation: _____

Electromyography (EMG) tests performed:

☐ Adult EMG

☐ Pediatric EMG

☐ Other: _____

Approximate number of tests performed: Daily _____ Annually _____

Nerve conduction studies (NCS) performed:

☐ Adult NCS

☐ Pediatric NCS

☐ Motor nerve conduction study

☐ Sensory nerve conduction study

☐ Other: _____

Who performs the NCS? ◯ Physician ◯ Technologists

Approximate number of tests performed: Daily _____ Annually _____

Facility Information for Initial Assessment *continued*

EQUIPMENT LIST

Description of equipment: _____

Make: _____ Model/serial number: _____

Year manufactured: _____ Location (e.g. room number): _____

Description of equipment: _____

Make: _____ Model/serial number: _____

Year manufactured: _____ Location (e.g. room number): _____

Description of equipment: _____

Make: _____ Model/serial number: _____

Year manufactured: _____ Location (e.g. room number): _____

Description of equipment: _____

Make: _____ Model/serial number: _____

Year manufactured: _____ Location (e.g. room number): _____

Who is responsible for the maintenance of diagnostic equipment? _____

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 neurodiagnostics@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).