COLLEGE OF PHYSICIANS AND SURGEONS OF BRITISH COLUMBIA

DIAGNOSTIC ACCREDITATION PROGRAM

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300–669 Howe Street
Vancouver BC V6C 0B4
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Facility Information for Initial Assessment

NEURODIAGNOSTICS – HEALTH AUTHORITY

FACILITY INFORMATION

Hospital/health centre name: _____

Health authority: _____

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: _____

Facility Information for Initial Assessment *continued*

LEADERSHIP

Regional administrative leader

Name: _____ Title: _____

Email address: _____ Location: _____

Regional medical leader

Name: _____ Title: _____

Email address: _____ Location: _____

Health service area, administrative leader

Name: _____ Title: _____

Email address: _____ Location: _____

Health service area, medical leader

Name: _____ Title: _____

Email address: _____ Location: _____

Medical leader of neurodiagnostics service

Name: _____ Title: _____

Email address: _____ Location: _____

Administrative leader of neurodiagnostics service

Name: _____ Title: _____

Email address: _____ Location: _____

Technical leader of neurodiagnostics service (e.g. chief technologist)

Name: _____ Title: _____

Email address: _____ Location: _____

Other individuals appointed to leadership positions

Name: _____ Title: _____

Email address: _____ Location: _____

Name: _____ Title: _____

Email address: _____ Location: _____

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: __________

Is there an interpreting physician present on-site during testing? ◯ Yes ◯ No

Are tests **transferred to** other facilities for interpretation? ◯ Yes - Specify below: ◯ No

Name: ______________________ Location: __________

Test: ______________________ Method of distribution: __________

Name: ______________________ Location: __________

Test: ______________________ Method of distribution: __________

Name: ______________________ Location: __________

Test: ______________________ Method of distribution: __________

Are tests **received from** other facilities for interpretation? ◯ Yes - Specify below: ◯ No

Location: __________ Test: __________ Method of distribution: __________

Location: __________ Test: __________ Method of distribution: __________

Location: __________ Test: __________ Method of distribution: __________

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: _____

Dedicated staff or rotate through the area? ◯ Dedicated ◯ Rotate

Days and hours of operation: _____

Are on-call services provided? ◯ Yes ◯ No

Projected number of test performed: Daily _____ Annually _____

Number of procedure rooms: _____

Are there tests that are only performed by specialized technical staff? ◯ Yes ◯ No

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? _____

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: _____

Dedicated staff or rotate through the area? ◯ Dedicated ◯ Rotate

Days and hours of operation: _____

Approximate number of tests performed: Daily _____ Annually _____

Number of procedure rooms: _____

Are EPs performed outside of the department? ◯ Yes ◯ No

If yes, please indicate location: _____

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? _____

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: _____

Dedicated staff or rotate through the area? ◯ Dedicated ◯ Rotate

Days and hours of operation: _____

Number of procedure rooms: _____

Electromyography (EMG) tests performed:

☐ Adult EMG

☐ Pediatric EMG

☐ Other: _____

Approximate number of tests performed: Daily _____ Annually _____

Are there dedicated days when tests are performed? ◯ Yes ◯ No

If yes, explain: _____

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 _____

Are NCS performed outside of the department? ◯ Yes ◯ No

If yes, please indicate location: _____

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).