DIAGNOSTIC ACCREDITATION PROGRAM
College of Physicians and Surgeons of British Columbia
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Toll Free: 1-800-461-3008 (in BC)
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Facility Information for Initial Assessment

PULMONARY FUNCTION – HEALTH AUTHORITY

FACILITY INFORMATION

Hospital/health centre name: _____

Health authority: _____

Pulmonary function service name: _____

Address: _____

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

CONTACT PERSON FOR PULMONARY FUNCTION 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*

SCOPE OF PULMONARY FUNCTON LABORATORY TESTING

☐ **Category IIA**

- ☐ Simple screening spirometry without bronchodilators
- ☐ Spirometry – before and after bronchodilators
- ☐ Peak expiratory flow rate

☐ **Category IIB**

- ☐ Simple screening spirometry without bronchodilators
- ☐ Spirometry – before and after bronchodilators
- ☐ Peak expiratory flow rate
- ☐ Spirometry – forced expiratory – without bronchodilators
- ☐ Spirometry – forced expiratory – before and after bronchodilators

☐ **Category III**

- ☐ Overnight home oximetry
- ☐ Simple screening spirometry without bronchodilators
- ☐ Spirometry – before and after bronchodilators
- ☐ Peak expiratory flow rate
- ☐ Lung volumes
- ☐ Spirometry – forced expiratory – without bronchodilators
- ☐ Spirometry – forced expiratory – before and after bronchodilators
- ☐ Diffusion studies with carbon monoxide

☐ **Category IV**

- ☐ IVA flow volume loops without bronchodilators
- ☐ IVA flow volume loops before and after bronchodilators
- ☐ IVB progressive exercise test
- ☐ IVB ventilation at rest/exercise with blood gases
- ☐ IVB exercise in a steady state
- ☐ IVB exercise in a steady state – AA gradients
- ☐ IVC exercise induced asthma
- ☐ IVD inhalation challenge
- ☐ IVE CO_2/O_2 responsive of respiratory centres
- ☐ IVF plethysomnography
- ☐ IVH preciptin tests
- ☐ IVI oximetry at rest, with or without oxygen
- ☐ IVI oximetry at rest and exercise, with or without oxygen
- ☐ IVK inspiratory and expiratory muscle strength

Facility Information for Initial Assessment *continued*

LEADERSHIP

Regional pulmonary function laboratory administrative leader

Name: _____ Title: _____

Email address: _____ Location: _____

Regional pulmonary function laboratory medical leader

Name: _____ Title: _____

Email address: _____ Location: _____

Health service area, pulmonary function laboratory administrative leader

Name: _____ Title: _____

Email address: _____ Location: _____

Health service area, pulmonary function laboratory medical leader

Name: _____ Title: _____

Email address: _____ Location: _____

Medical leader of pulmonary function laboratory

Name: _____ Title: _____

Email address: _____ Location: _____

Administrative leader of pulmonary function laboratory

Name: _____ Title: _____

Email address: _____ Location: _____

Technical leader of pulmonary function laboratory (e.g. chief therapist)

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: __________

Category interpreting: ☐ II A ☐ II B ☐ III ☐ IV A ☐ IV B ☐ IV C ☐ IV D ☐ IV E ☐ IV F ☐ IV H ☐ IV I ☐ IV K

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

Name: ____________________ CPSID: __________

Category interpreting: ☐ II A ☐ II B ☐ III ☐ IV A ☐ IV B ☐ IV C ☐ IV D ☐ IV E ☐ IV F ☐ IV H ☐ IV I ☐ IV K

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

Name: ____________________ CPSID: __________

Category interpreting: ☐ II A ☐ II B ☐ III ☐ IV A ☐ IV B ☐ IV C ☐ IV D ☐ IV E ☐ IV F ☐ IV H ☐ IV I ☐ IV K

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

Name: ____________________ CPSID: __________

Category interpreting: ☐ II A ☐ II B ☐ III ☐ IV A ☐ IV B ☐ IV C ☐ IV D ☐ IV E ☐ IV F ☐ IV H ☐ IV I ☐ IV K

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

Name: ____________________ CPSID: __________

Category interpreting: ☐ II A ☐ II B ☐ III ☐ IV A ☐ IV B ☐ IV C ☐ IV D ☐ IV E ☐ IV F ☐ IV H ☐ IV I ☐ IV K

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

Name: ____________________ CPSID: __________

Category interpreting: ☐ II A ☐ II B ☐ III ☐ IV A ☐ IV B ☐ IV C ☐ IV D ☐ IV E ☐ IV F ☐ IV H ☐ IV I ☐ IV K

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

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

Facility Information for Initial Assessment *continued*

PULMONARY FUNCTION

Days and hours of operation: _____

Number of technical staff (FTE): _____

Therapists are Canadian Society of Respiratory Therapists (CSRT) certified or are eligible to write the Canadian Board for Respiratory Care (CBRC) 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: _____

Are pediatric examinations performed? ◯ Yes ◯ No

Is blood gases testing done within the laboratory? ◯ Yes ◯ No

Approximate number of tests performed: Daily _____ Annually _____

TEST REPORTING AND INTERPRETATION

Are studies **tranferred to** other facilities for interpretation? ◯ Yes ◯ No

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

Name	Location	Method 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 location and method of distribution:

Location	Mode of distribution
Example: XYZ Hospital/Health Centre	Courier

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 pulmonaryfunction@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).