



DIAGNOSTIC ACCREDITATION PROGRAM
College of Physicians and Surgeons of British Columbia

300-669 Howe Street
Vancouver BC V6C 0B4
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Toll Free: 1-800-461-3008 (in BC)
Fax: 604-733-3503

Facility Information for Initial Assessment

POLYSOMNOGRAPHY – COMMUNITY

FACILITY INFORMATION

Facility name: _____

Address: _____

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

SCOPE OF POLYSOMNOGRAPHY TESTING

- | | |
|---|---|
| <input type="checkbox"/> Adult polysomnography | <input type="checkbox"/> Pediatric polysomnography |
| <input type="checkbox"/> Multiple sleep latency test (MSLT) | <input type="checkbox"/> Maintenance wakefulness test (MWT) |
| <input type="checkbox"/> Overnight oximetry | <input type="checkbox"/> Actigraphy |
| <input type="checkbox"/> Four channel portable test | |

CONTACT PERSON FOR POLYSOMNOGRAPHY 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

Organization administrative leader

Name: _____ Title: _____

Email address: _____ Location: _____

Organization medical leader

Name: _____ Title: _____

Email address: _____ Location: _____

Medical leader of polysomnography service

Name: _____ Title: _____

Email address: _____ Location: _____

Administrative leader of polysomnography service

Name: _____ Title: _____

Email address: _____ Location: _____

Technical leader of polysomnography 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: <input type="checkbox"/> Adult polysomnography | <input type="checkbox"/> Pediatric polysomnography |
| Location: <input type="radio"/> On-site | <input type="radio"/> Off-site – specify location: _____ |
| Name: _____ | CPSID: _____ |
| Tests interpreting: <input type="checkbox"/> Adult polysomnography | <input type="checkbox"/> Pediatric polysomnography |
| Location: <input type="radio"/> On-site | <input type="radio"/> Off-site – specify location: _____ |
| Name: _____ | CPSID: _____ |
| Tests interpreting: <input type="checkbox"/> Adult polysomnography | <input type="checkbox"/> Pediatric polysomnography |
| Location: <input type="radio"/> On-site | <input type="radio"/> Off-site – specify location: _____ |
| Name: _____ | CPSID: _____ |
| Tests interpreting: <input type="checkbox"/> Adult polysomnography | <input type="checkbox"/> Pediatric polysomnography |
| Location: <input type="radio"/> On-site | <input type="radio"/> Off-site – specify location: _____ |
| Name: _____ | CPSID: _____ |
| Tests interpreting: <input type="checkbox"/> Adult polysomnography | <input type="checkbox"/> Pediatric polysomnography |
| Location: <input type="radio"/> On-site | <input type="radio"/> Off-site – specify location: _____ |

POLYSOMNOGRAPHY

Days and hours of operation: _____

Number of technical staff (FTE): _____

Technologists are: BRPT certified RPSGT certified **If neither, specify below.**

Name: _____ Qualifications: _____

Name: _____ Qualifications: _____

Name: _____ Qualifications: _____

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

Name: _____ Title: _____

Number of beds: _____

Approximate number of test performed: Daily _____ Annually _____

Facility Information for Initial Assessment *continued*

TEST REPORTING AND INTERPRETATION

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

Name: _____ Location: _____ Method of distribution: _____

Name: _____ Location: _____ Method of distribution: _____

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

Location: _____ Method of distribution: _____

Location: _____ Method of distribution: _____

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*

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 polysomnography@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).