COLLEGE OF PHYSICIANS AND SURGEONS OF BRITISH COLUMBIA

DIAGNOSTIC ACCREDITATION PROGRAM

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300–669 Howe Street
Vancouver BC V6C 0B4
Canada

cpsbc.ca

Facility Information for Initial Assessment

POLYSOMNOGRAPHY – COMMUNITY

FACILITY INFORMATION

Facility name: _____

Address: _____

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

SCOPE OF POLYSOMNOGRAPHY TESTING

- ☐ Adult polysomnography
- ☐ Pediatric polysomnography
- ☐ Multiple sleep latency test (MSLT)
- ☐ Maintenance wakefulness test (MWT)
- ☐ Overnight oximetry
- ☐ Actigraphy
- ☐ 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: ☐ Adult polysomnography ☐ Pediatric polysomnography

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

Name: ______________________ CPSID: __________

Tests interpreting: ☐ Adult polysomnography ☐ Pediatric polysomnography

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

Name: ______________________ CPSID: __________

Tests interpreting: ☐ Adult polysomnography ☐ Pediatric polysomnography

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

Name: ______________________ CPSID: __________

Tests interpreting: ☐ Adult polysomnography ☐ Pediatric polysomnography

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

Name: ______________________ CPSID: __________

Tests interpreting: ☐ Adult polysomnography ☐ Pediatric polysomnography

Location: ◯ On-site ◯ 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).