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

Proficiency Testing Investigation Response Form

LABORATORY AND PT INFORMATION

Laboratory: _____ Contact phone number: _____

Date: _____ ◯ Proactive response ◯ Response to DAP request

Investigation response due within eight weeks of PT results receipt.

PT provider: _____ PT program: _____ Sample ID: _____

Results deadline date: _____

☐ Copy of PT provider's final evaluation report. Attach page(s) showing outlier (required).

Analyte/test: _____ ☐ Multiple analytes flagged due to common cause

(submit only one investigation form)

PT EXCEPTION INVESTIGATION

QC results at time of PT challenge: ◯ Acceptable ◯ Not acceptable

Comments:

Previous PT/QC trends or unacceptable results for this test? ◯ Yes ◯ No

If yes, indicate investigation/corrective action:

Was sample retested?

◯ Yes – Result: _____

Was the result of the retested sample acceptable? ◯ Yes ◯ No

◯ No – Sample unsuitable for repeat analysis

◯ No – Explain why retesting was not performed: _____

Were patient results affected? ◯ Yes ◯ No

If yes, indicate investigation/corrective action:

Proficiency Testing Investigation Response Form *continued*

PT EXCEPTION RESPONSE

Classification of problem:

☐ Method ☐ Equipment ☐ Technical
☐ Problem with material ☐ Clerical ☐ Problem with evaluation of results
☐ No explanation after complete investigation (all means of explaining the discrepancy have been exhausted and all possible explanations have been considered)

Details:

Identification of root cause/contributing factors, if known:

Corrective action/system change(s) to prevent recurrence:

Comments/conclusions:

Submit separate files if additional space is required to describe the investigation.

SIGN-OFF

The DAP holds the laboratory director responsible for defining and monitoring standards of performance and ensuring the quality of results. The laboratory director must be advised of all proficiency test result deficiencies.

Laboratory supervisor or designate

Name: _____ Email: _____

Signature: _____ Date: _____

Laboratory medical director

Name: _____

Signature *(required only when a response is requested from the DAP)*: _____ Date: _____

Please return the completed form by email at ptqc@cpsbc.ca.

The information on this form is collected under the authority of section 5-26 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).

DAP USE ONLY

Received: Reviewed: Follow-up required: