DIAGNOSTIC ACCREDITATION PROGRAM
College of Physicians and Surgeons of British Columbia

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Facility Information for Initial Assessment

COMMUNITY SPIROMETRY

FACILITY INFORMATION

Facility name: ______________________________

Health authority (if applicable): ______________________________

Address: ______________________________

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

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 IV**

- ☐ IVA flow volume loops without bronchodilators
- ☐ IVA flow volume loops before and after bronchodilators

Tests performed: ☐ Adult ☐ Pediatric

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*

LEADERSHIP

For facilities that are affiliated with a health authority.

Regional pulmonary function laboratory administrative leader

Name: ________________ Title: ________________

Email address: ________________ Location: ________________

Regional 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. professional practice leader)

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: ________________

Hospital health centre COO/administrator

Name: ________________ Title: ________________

Email address: ________________ Location: ________________

Facility Information for Initial Assessment *continued*

LEADERSHIP

*For facilities that are **not** affiliated with a health authority.*

Medical leader

Name: ______________________ Title: ______________________

Email address: ______________________ Location: ______________________

Administrative leader

Name: ______________________ Title: ______________________

Email address: ______________________ Location: ______________________

Technical leader (chief technologist/manager)

Name: ______________________ Title: ______________________

Email address: ______________________ Location: ______________________

Other individual appointed to leadership positions

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: __________

Physician Information

Credentialing for physicians who hold privileges at any health authority facility is performed by the health authority, and includes assessing eligibility for MSP billings for restricted services. Many medical offices are owner operated solo practices and the physician may not hold privileges with a health authority; therefore, the physician would not have proceeded through a credentialing process. In these instances, the physician is licensed to their scope of practice through the College of Physicians and Surgeons of BC. For MSP billing purposes for a restricted diagnostic service, the College will review the associated credentials required to be eligible to bill for these services and will notify MSP of the eligibility. For further information please contact credentialing@cpsbc.ca.

If only spirometry is performed and the spirometer used is exclusively the **COPD-6 Spirometer**, as approved by the Medical Services Commission for case finding, then credentialing by the College is not required.

Facility Information for Initial Assessment *continued*

PULMONARY FUNCTION

Number of spirometers at this location: ______

Is/are the spirometers shared amongst the physicians in the office, or do some spirometers have a designated physician who uses them?

◯ Shared use ◯ Dedicated use ◯ Both

Is/are the spirometers used at any other location in the province? ◯ Yes ◯ No

If yes, please indicate location/address: ______

Is testing performed by the physician(s)? ◯ Yes ◯ No

If no, please specify:

Name: ______ Qualifications: ______

Name: ______ Qualifications: ______

Name: ______ Qualifications: ______

Is a formal requisition generated prior to patient testing? ◯ Yes ◯ No

Anticipated number of tests per year: ______

EQUIPMENT LIST

Spirometer identifier: ______

Manufacturer: ______ Model/serial number: ______

Year manufactured: ______ Date of last software upgrade: ______

Software version: ______

Spirometer identifier: ______

Manufacturer: ______ Model/serial number: ______

Year manufactured: ______ Date of last software upgrade: ______

Software version: ______

Spirometer identifier: ______

Manufacturer: ______ Model/serial number: ______

Year manufactured: ______ Date of last software upgrade: ______

Software version: ______

Note: *Even newer spirometers may not be up to date with current ATS/ERS guidelines if the manufacturer does not/did not upgrade the software. Please ensure that your software is current with the 2005 ATS/ERS Spirometry guidelines.*

Facility Information for Initial Assessment *continued*

PREPARATION FOR TESTING

Is calibration performed with a 3-liter calibration syringe? ◯ Yes ◯ No

Date of expiry for 3L syringe: ______________________________

Prior to patient testing:

Is the spirometer calibrated? ◯ Yes ◯ No

Are temperature, barometric pressure, and relative humidity updated? ◯ Yes ◯ No

Is a height and weight scale used? ◯ Yes ◯ No

Is date of birth verified? ◯ Yes ◯ No

Who is responsible for the maintenance of diagnostic equipment? ______________________________

BRONCHODILATORS

Is pre- and post-bronchodilator testing performed? ◯ Yes ◯ No

Method of delivery: ◯ Nebulizer ◯ Metered dose inhaler

Dosage: ____ mg ____ µg

Is a spacer/valved holding chamber used? ◯ Yes ◯ No

Administration of medication (bronchodilator): ◯ Physician ◯ Other

If other, please specify: ______________________________

Has the act of administering medication been formally delegated? ◯ Yes ◯ No

If no, please explain: ______________________________

Note: *A* delegation of a medical act occurs when a physician authorizes another person to perform a medical act who is not authorized to do so as part of a *regulated* professional scope of practice (e.g. administration of medication). *Consult the 2005 ATS/ERS Standards for Spirometry for proper administration of bronchodilators.*

Facility Information for Initial Assessment *continued*

INFECTION CONTROL

Are the following items disposed of after each use?

Spirometer mouthpiece	◯ Yes	◯ No, explain: ________
Spacer/valve holding chamber	◯ Yes	◯ No, explain: ________
Nebulizer	◯ Yes	◯ No, explain: ________
Nose clips	◯ Yes	◯ No, explain: ________

Are the following performed?

Hand washing before and after patient interaction	◯ Yes	◯ No, explain: ________
Alcohol based hand rub where applicable	◯ Yes	◯ No, explain: ________
Gloves used for handling soiled equipment (e.g. mouthpieces)	◯ Yes	◯ No, explain: ________
Hand-held devices used by patients cleaned between uses	◯ Yes	◯ No, explain: ________
Surfaces in direct contact with a patient are cleaned and disinfected before use with another patient	◯ Yes	◯ No, explain: ________

PROCEDURE MANUAL

Does the facility have a written procedure manual for spirometry testing in addition to the spirometer manufacturer documentation? ◯ Yes ◯ No

PATIENTS

Provide the predicted set/source of the normal values with which measurements will be compared:

Adult: ________________ Pediatric: ________________

Examples include: The National Health and Nutrition Survey (NHANES) III (1999), Morris, Knudson, ATS/ERS Global Lung Initiative

The patient and QC results are: ◯ Printed ◯ Stored electronically

Please include a copy of your patient spirometry requisition form. ◯ Included ◯ No form in use

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 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).