UC Davis Health Pathology and Laboratory
New Test/Product/Process Request Form

INSTRUCTIONS

The Department of Pathology and Laboratory Medicine approves all new *in vitro* diagnostic tests including tests performed at the facility, blood products under transfusion services as well as tests performed at referral facilities. Requests are reviewed by Pathology and Laboratory Medicine. Additional review may be required via the hospital Laboratory Test Utilization Committee. Please fill out the form and address all items. Requestor email completed form to hs-newlabtest@ucdavis.edu.
If the specimen has already been collected please return form within 24 hours.

A. REQUESTING PROVIDER / SERVICE / CONTACT

Requesting Provider:	
Hospital Department / Division:	
Email:	Phone#:

B. TEST/PRODUCT CATEGORY

New Test/Product Name:
Preferred Reference Lab (if applicable):
Test Description:
Test Methodology:
Anticipated Number of Tests/Products Used Per Day/Month/Year:
Estimated Cost/Reimbursement:
Cost/Price Analysis for Alternate Referral Testing Laboratory:
If this test is replacing an existing standard approach to care, please explain:

TEST/PRODUCT UTILIZATION:

Demographic (check all that apply): ☐ Inpatient ☐ Outpatient ☐ Emergency Department

Clinical Trials / Research: New tests/products/processes for research must also complete the Pathology Clinical Research Oversight Committee (CROC) intake form:
https://ctscassist.ucdmc.ucdavis.edu/ctscassist/surveys/?s=TFTKKYMTFM

C. MEDICAL NECESSITY AND REFERENCES

Provide a detailed explanation of medical necessity/how results of requested test/product(s) will influence patient clinical management and care. If the patient is a hospital in-patient, please explain how these results will influence the treatment plan during current admission. Requests for alternative tests/products that are either available in-house or through an existing approved referral laboratory require inclusion of clinical and analytical data (*i.e.,* literature) explaining why one method is better than another.
This portion is critical for proper medical director evaluation of the requested laboratory testing.

REQUESTING DEPARTMENT CHAIR / DIVISION CHIEF APPROVAL

Signature:_____ Print Name:_____ Date: _____

REVENUE INTEGRITY PROGRAM REVIEW/APPROVAL

Signature:_____ Print Name:_____ Date: _____

PATHOLOGY USE ONLY

Primary Laboratory Section:	Other(?):
Section Supervisor / Manager:	

Status: ◉ Approved ○ Not Approved

Section Medical Director: