**New Test Addition Request Form**

Requests for the addition of new laboratory tests undergo a structured approval process. These requests are submitted to PaLM Senior Leadership for consideration. Subsequently, all requests, along with supporting evidence and cost considerations, are thoroughly reviewed during scheduled meetings, as deemed appropriate. Following these deliberations, the applicant is notified of the status of their application.

**Note: Point of Care test/equipment requests can be made using the form linked** [**here**](https://lhsc.omni-assistant.net/lab/Document/DocumentDownloader.aspx?Df_Guid=29e6e4e9-7cab-4b29-a6da-8a03082a7ad5)**.**

It is important to note that, given the fiscal constraints, any requests for new tests that would increase costs within the LHSC budget must be accompanied by a well-defined strategy to counterbalance the cost impact. This strategy may encompass various approaches, such as identifying cost savings within clinical areas, exploring substitution options, or reducing the usage of existing lab testing. These reductions must be significant, feasible, attainable, and capable of delivering measurable savings.

**PART 1** – **DESCRIPTION OF THE NEW TEST REQUEST**

To be completed by the requestor.

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| 1. **CONTACT INFORMATION**
 |
| Name of Requestor(s): | Click or tap here to enter text. | Hospital:  | UH [ ]  VH [ ]   |
| Dept./Division: | Click or tap here to enter text. |
| Physician/Executive Lead: | Click or tap here to enter text. |
| Director: | Click or tap here to enter text. |
| Phone Number and Pager: | Click or tap here to enter text. | Email: | Click or tap here to enter text.  |
| Signature: |  | Date Submitted: | Click or tap to enter a date. |
| Provide the names of any PaLM staff members who collaborated on this submission: | Click or tap here to enter text. |

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| 1. **CONFLICT OF INTEREST DECLARATION:**
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| Is there any conflict of interest associated with this request? [ ]  YES [ ]  NO (Examples: Financial, personal (relationship), professional, intellectual (IP), contractual, vendor/supplier etc.)If yes, please specify:Click or tap here to enter text. |

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| 1. **PROPOSED TEST INFORMATION:**
 |
| Test Name: | Click or tap here to enter text. |
| Estimated Annual Volume: | Click or tap here to enter text. |
| Replaces Existing Test? | [ ]  YES [ ]  NOIf yes, please specify the test: Click or tap here to enter text. |
| Does the proposed test improve sensitivity or specificity? Provide specific details. | Click or tap here to enter text. |
| What is the desired turnaround time for diagnostic purposes? e.g. hours, days, weekdays only, 24/7 etc. | Click or tap here to enter text. |
| What is the urgency of this request? Is there a proposed timeframe for this test to be made available for diagnostic purposes? | Click or tap here to enter text. |

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| 1. **STRATEGIC PRIORITY, BENEFITS AND EVIDENCE**
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| [Strategic Priority](https://www.lhsc.on.ca/strategicplan) | [ ]  Team LHSC [ ]  Integrated Care [ ]  Advancing Excellence |
| Clinical Impact – Describe the patient population, indication and benefit of the test to the target population. How will the test impact patient care? What outcomes will we measure to assess impact? Be specific (e.g. Length of Stay (LOS), use of ancillary testing or drugs, patient access and flow) | Click or tap here to enter text. |
| Supporting Evidence – Please summarize all relevant key evidence by stating patient population, indication, comparator and outcomes in supporting references. (list and attach electronic copies of all references) | Click or tap here to enter text. |
| [Patient Engagement](https://intra.lhsc.on.ca/patient-experience/patient-engagement) – Was a *Patient and Family Partner* consulted in this request? Describe how this test will improve the patient experience. | [ ]  YES [ ]  NO Click or tap here to enter text. |
| Preferred manufacturer(s) if any, and rationale: | Click or tap here to enter text. |
| Is this test Health Canada approved? | [ ]  YES [ ]  NO [ ]  Unknown |
| Is funding available to support this request? (ex. Donations, grants etc.) | [ ]  YES [ ]  NOIf yes, please describe: Click or tap here to enter text. |

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| 1. **INCLUDE SIGNATURES OF ENDORSEMENT FROM THOSE IN SUPPORT OF THIS REQUEST**

(Example: Physician Lead, Department Director, Executive etc.) |
| Name: Click or tap here to enter text.Title: Click or tap here to enter text. |  |
| Name: Click or tap here to enter text.Title: Click or tap here to enter text. |  |
| Name: Click or tap here to enter text.Title: Click or tap here to enter text. |  |
| Submit this form to lab@lhsc.on.ca |

**PART 2** – **NEW TEST ADDITION REVIEW**

To be completed by PaLM Manager, Program /Division /Section Heads and/or Director.

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| 1. **PRELIMINARY COST ANALYSIS**

(Include all costs of all additional supplies and/or consumable items where relevant) |
| **NEW Test Information** |
| Test Name | Manufacturer | Price Per Each ($) | Annual Volume | Break Down by Hospital(if required) | Total AdditionalCost ($) |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| **Comments**:Click or tap here to enter text. | **Total [A]:**Click or tap here to enter text. |
| **CURRENT Test Information (Only for volumes that WILL NO LONGER BE REQUIRED)** |
| Test Name | Manufacturer | Price Per Each ($) | Annual Volume | Break Down by Hospital(if required) | Total AdditionalCost ($) |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| **Comments**:Click or tap here to enter text. | **Total [B]:**Click or tap here to enter text. |

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| **Financial Impact Assessment** |
| **Areas of Cost Impact** | **Description** | **Annual Cost Impact ($):** **+ for increase, - for decrease** |
| **Financial Impact of Test** |
| Increased use: from above table marked [**A**] | Click or tap here to enter text. | Click or tap here to enter text. |
| Reduced use: from above table marked [**B**] | Click or tap here to enter text. | Click or tap here to enter text. |
| Any other Financial Impact not included in the items above: | Click or tap here to enter text. | Click or tap here to enter text. |
| **Total Financial Impact of Test:** | Click or tap here to enter text. |
| **Additional Financial Impact in Laboratory Areas:** |
| Staffing costs:  | Click or tap here to enter text. | Click or tap here to enter text. |
| Supplies costs:  | Click or tap here to enter text. | Click or tap here to enter text. |
| Equipment costs:  | Click or tap here to enter text.Is Capital required?Choose an item. | Click or tap here to enter text. |
| Funding/revenue impact: | Click or tap here to enter text. | Click or tap here to enter text. |
| **Total Financial Impact in Laboratory Areas:** | Click or tap here to enter text. |
| **Financial Impact in Clinical Areas:** (Complete if required in consultation with clinical leadership) |
| Staffing costs:  | Click or tap here to enter text. | Click or tap here to enter text. |
| Supplies costs:  | Click or tap here to enter text. | Click or tap here to enter text. |
| Funding/revenue impact: | Click or tap here to enter text. | Click or tap here to enter text. |
| **Total Financial Impact in Clinical Areas:** | Click or tap here to enter text. |
| **Total Net Financial Impact:** | **Click or tap here to enter text.** |

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| 1. **UTILIZATION MANAGEMENT**
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| Identify the expected requestors of this test. Should there be restrictions on who can order this? Would a minimum retesting interval for repeat testing be specified? | Click or tap here to enter text. |
| Please describe proposed follow-up evaluation process to assess test utilization. Define tentative time frames. | Click or tap here to enter text. |

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| 1. **CONTRACT ASSESSMENT**
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| Does this request affect current departmental contracts? [ ]  YES [ ]  NOIs there opportunity for evaluation/standardization city-wide? [ ]  YES [ ]  NOPlease describe and quantify any financial impact:Click or tap here to enter text. |

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| 1. **CAPITAL ASSESSMENT**
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| Does this request require a capital purchase (>$5K)? [ ]  YES [ ]  NOIs the total value over the life of the agreement or equipment >$100K? [ ]  YES [ ]  NOIf yes, which process will be utilized?[ ]  Request for Proposal (RFP >$100K)[ ]  Leverage of a Group Purchasing Organization (GPO) contract[ ]  Competitive Bidding Exemption (CBE)[ ]  Advance Contract Award Notice (ACAN)  |

| 1. **REQUEST EVALUATION INFORMATION**
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| Formal business plan required? | [ ]  YES [ ]  NOClick or tap here to enter text. |
| Is an in-service or education required prior to approving this request? | [ ]  YES [ ]  NOClick or tap here to enter text. |
| Is a trial required? | [ ]  YES [ ]  NOClick or tap here to enter text. |
| Will the test be performed in-house or referred out? | [ ]  In-house [ ]  Referred Out Click or tap here to enter text. |
| Do we have the capacity to support this request? Comment on existing staffing, workload and space. | [ ]  YES [ ]  NOClick or tap here to enter text. |
| Will there be an impact to regional partners? Will the test be offered to the region? | [ ]  YES [ ]  NOClick or tap here to enter text. |
| How will the test be funded?  | [ ]  Existing Funding [ ]  Net New [ ]  Donations/Grants Click or tap here to enter text. |
| Risk assessment required?(If yes, attach risk assessment) | [ ]  YES [ ]  NOClick or tap here to enter text. |
| Planning/physical facilities approval required? Other maintenance/ renovation needs?(Attach a plan/costs/approval) | [ ]  YES [ ]  NOClick or tap here to enter text. |
| HMMS review/approval required? | [ ]  YES [ ]  NOClick or tap here to enter text. |
| Biomed review/approval required?(Attach approval, if applicable) | [ ]  YES [ ]  NOClick or tap here to enter text. |
| ITS review/approval required?(Attach approval, if applicable) | [ ]  YES [ ]  NOClick or tap here to enter text. |
| Power plan /clinical informatics work required? | [ ]  YES [ ]  NOClick or tap here to enter text. |
| PathNet/LIS support required? | [ ]  YES [ ]  NOClick or tap here to enter text. |
| Ethics assessment required?(If yes, attach assessment) | [ ]  YES [ ]  NOClick or tap here to enter text. |
| Safety assessment required?(OHSS and/or JHSC) | [ ]  YES [ ]  NOClick or tap here to enter text. |
| [Patient Engagement](https://intra.lhsc.on.ca/patient-experience/patient-engagement) – Is there an opportunity to consult a *Patient and Family Partner*?  | [ ]  YES [ ]  NOClick or tap here to enter text. |
| Laboratory licensing changes required? | [ ]  YES [ ]  NOIf yes, what is the test code to be added? Click or tap here to enter text.Which test code needs to be removed, if applicable? Click or tap here to enter text. |
| Collaboration with other PaLM or LHSC departments required? | [ ]  YES [ ]  NOClick or tap here to enter text. |

Submit completed form to PaLM Senior Leadership Team (SLT).

**PART 3 – CONCLUSION AND SIGNATURES**

To be completed by PaLM Manager, Director, and/or Program /Division /Section Heads. Return *Part 3* to the requestor.

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| 1. **CONCLUSION**
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| Test Name: | **Click or tap here to enter text.** |
| Decision: *(Include rationale and tentative implementation timeline)* | Click or tap here to enter text. | **Status**Choose an item. |
| **Decision Date**Click or tap to enter a date. |
| ManagerName: Click or tap here to enter text. | *Signature* |
| Program /Division /Section HeadName: Click or tap here to enter text. | *Signature* |
| DirectorName: Click or tap here to enter text. | *Signature* |
| This request has been reviewed and approved by: | [ ]  PaLM Senior Leadership Team (SLT) Date: Click or tap to enter a date. [ ]  LHSC Executive Leadership Collaborative (ELC)Date: Click or tap to enter a date. [ ]  Medical Advisory Committee (MAC)Date: Click or tap to enter a date. [ ]  Other: Click here to enter text. Date: Click or tap to enter a date.  |
| Name of Requestor: | Click or tap here to enter text. | Date Requestor Notified: | Click or tap to enter a date. |

**PART 4** – **UTILIZATION AND CLINICAL IMPACT REVIEW**

To be completed by the PaLM Manager, Director, and/or Program /Division /Section Heads in conjunction with the requestor post implementation.

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| 1. **CONTROLLING UTILIZATION**
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| What is the test volume? Has this changed from the anticipated volume? | Click or tap here to enter text. |
| Describe current utilization strategies in place: | Click or tap here to enter text. |
| What strategies can be implemented to improve utilization? Consider minimum retesting intervals, ordering restrictions, specific criteria for ordering etc.  | Click or tap here to enter text. |

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| 1. **CLINICAL IMPACT**
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| Describe the clinical impact. Examples: Patient outcomes, length of stay, patient experience etc. | Click or tap here to enter text. |
| What strategies can be implemented to improve utilization? Consider minimum retesting intervals, ordering restrictions, specific criteria for ordering etc.  | Click or tap here to enter text. |

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| 1. **LABORATORY IMPACT**
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| If this test replaced an existing test, has the volume of the old test reduced as expected?  | Click or tap here to enter text. |
| Are turnaround times met?  | Click or tap here to enter text. |
| Describe any staff, training, process or equipment issues to be addressed? | Click or tap here to enter text. |

| 1. **POST IMPLEMENTATION REVIEW**
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| Utilization and clinical impact have been reviewed:[ ]  No further follow-up required.[ ]  Follow-up required. Date Scheduled: Click or tap to enter a date.Additional Comments: Click or tap here to enter text. | Review Date:  | Click or tap to enter a date. |
| Name | Title | Department |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
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