**Approval Form for Purchase of New Ultrasound Equipment**



*This form is to be completed prior to the purchase of any new ultrasound equipment. After completion, this form is required to be submitted as an attachment to your purchase requisition and the vendor quotation. All appropriate approvals must be completed prior to a purchase order being issued.*

**Facility and Department**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Departmental VP**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Equipment being requested** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *(Manufacturer and Model)*

**Describe the reason for the request, who will be using it, and clinical necessity if the device is not a replacement for an existing device.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Cardiology and Radiology Ultrasounds**

**Is this equipment a health system standard?** \_\_\_\_Yes \_\_\_\_No

*If* ***Yes*** *skip to the end and obtain ISS Solutions approval.*

*If* ***No*** *you must obtain Clinical Technology Optimization and Standardization Committee (CTOSC) approval for an exception before proceeding.*

**All Other Ultrasounds**

Including all Point-of-Care devices

**Is this equipment a health system standard?**

*If* ***Yes*** *continue. If* ***No*** *you must obtain CTOSC approval for an exception before proceeding.*

**Will this device capture images?** \_\_\_\_Yes \_\_\_\_No

**If yes, into which Informatics System do you plan to archive ultrasound images?**

Please indicate the system: PACS Xcelera Q-Path Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Into which Informatics System do you plan to enter an interpretation?**

Please indicate the system: EPIC RIS Q-Path Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Will this device connect to the hospital network?** \_\_\_\_Yes \_\_\_\_No

**Does this device have wireless capabilities?** \_\_\_\_Yes \_\_\_\_No

**Will this device display, store, or transmit PHI?** \_\_\_\_Yes \_\_\_\_No

*If* ***Yes****, please check relevant PHI items below*:

**Do providers have appropriate credentialing**  \_\_\_\_Yes \_\_\_\_\_No

**privileges for Point-of-Care Ultrasound?**

|  |  |  |  |
| --- | --- | --- | --- |
| ☐ Account Numbers | ☐ Address Elements | ☐ Any Unique ID | ☐ Beneficiary # |
| ☐ Biometric IDs | ☐ Cert or License # | ☐ Date Elements | ☐ Device IDs / Serials |
| ☐ Email Address | **☐** Fax Numbers | ☐ Full Face Photos | ☐ IP Addresses |
| ☐ Medical Record # | ☐ Name Elements | ☐ Social Security # | ☐ Telephone Numbers |
| ☐ Vehicle IDs | ☐ Web URLs |  |  |

**Approvals**

 **Date**

**System Clinical Ultrasound Director\*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_

**CTSOC\*\* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_**

**ISS Solutions \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_**

***\* For Point-of-Care devices only***

***\*\* If CTOSC has granted an exception to the standard***