NEURODIAGNOSTICS

This form is to be completed and submitted to the DAP by an existing accredited facility that is preparing for a significant change in service related to: physical location, equipment, scope of testing, leadership, interpreting physicians and staffing model.

Note: The notification of significant change form must be submitted prior to the change commencing. If the change is related to physical location, equipment or scope of testing, patient testing must not commence until the scope of accreditation is confirmed.

If the change affects multiple facilities, a separate form must be submitted for each. Alternatively, a letter detailing the significant change, as per the form, may be submitted on behalf of multiple facilities.

Complete PDF form electronically. Do not print and scan.

FACILITY INFORMATION

Date of submission: ____________________

Facility/hospital/health centre name: ____________________

Address: ____________________

City: ____________________ Province: __________ Postal code: __________

Medical director (incumbent): ____________________

Phone: ____________________ Email: ____________________

Facility manager (incumbent): ____________________

Phone: ____________________ Email: ____________________

Facility contact (if different from facility manager): ____________________

Phone: ____________________ Email: ____________________

☐ The submitter has ensured that the information in this form has been reviewed by the facility medical director.

SIGNIFICANT CHANGE

Effective date of change: ____________________

☐ There will be a change in the physical location of the service (relocation/extensive renovations).

Include where the service(s) is being relocated and if the relocation is temporary or permanent.

Explain:

☐ There will be new, replacement, or additional diagnostic equipment to be installed.
For example, EEG or EMG machine.

Submit acceptance testing evidence and provide evidence that the medical director has approved the acceptance testing.

Complete the following table for each diagnostic equipment.

	Description of equipment	Make	Model/serial number	Year manufactured	Equipment to be replaced (if applicable)

☐ There will be a change in leadership (technical, medical, administrative).

Note: If there is a change in medical leadership, submit a completed Accreditation Agreement.

Name: __________

Title (e.g. medical director, site coordinator): __________

Phone: __________ Email: __________

Mailing address (if different from facility address): __________

Name of individual being replaced (if applicable): __________

☐ There will be a change in interpreting physicians and/or location of interpreting physicians.

Name: __________

CPSID: __________ Location: __________

Tests interpreting:

☐ Electroencephalography (EEG) ☐ Evoked Potentials (EP)

☐ Electromyography (EMG) ☐