TRICORE REFERENCE LABORATORIES

TEST IDENTIFICATION:________________________________ LOCATION (SITE/DEPARTMENT):________________________________

RISK ASSESSEMENT

	REAGENTS	RISK	supporting documentation/ mitigation	TEST SYSTEM	RISK	supporting documentation/ mitigation	OPERATORS	RISK	supporting documentation/ mitigation	SPECIMEN	RISK	supporting documentation/ mitigation	ENVIRONMENT	RISK	supporting documentation/ mitigation
PRE-ANALYTICAL															
ANALYTICAL															
POST-ANALYTICAL															

		TEST IDENTIFICATION:______________________________		LOCATION (SITE/DEPARTMENT):__________________
		QUALITY CONTROL PLAN		
		TYPE OF QUALITY CONTROL	FREQUENCY (specify the number, type and frequency of testing QC materials)	CRITERIA FOR ACCEPTABILITY (Range of Acceptable Values)
PRE ANALYTICAL	SPECIMEN			
	TEST SYSTEM			
	REAGENT			
	ENVIRONMENT			
	TESTING PERSONNEL			
ANALYTICAL	SPECIMEN			
	TEST SYSTEM			
	REAGENT			
	ENVIRONMENT			
	TESTING PERSONNEL			
POST ANALYTICAL	SPECIMEN			
	TEST SYSTEM			
	REAGENT			
	ENVIRONMENT			
	TESTING PERSONNEL			

Date: ____________________________ Medical Director Signature: ____

<table>
<tr><td colspan="2"> </td><td colspan="2">TEST IDENTIFICATION:____________________________________</td><td colspan="2">LOCATION (SITE/DEPARTMENT):_______________________</td></tr>
<tr><td colspan="6">QUALITY ASSESSMENT PLAN</td></tr>
<tr><td colspan="2"></td><td>QUALITY ASSESSMENT ACTIVITY
(to monitor)</td><td>FREQUENCY
(of monitoring)</td><td>ASSESSMENT OF QA ACTIVITY
(Was there variation from established policy and procedures?)</td><td>CORRECTIVE ACTION
(when indicated)</td></tr>
<tr><td rowspan="5">PRE ANALYTICAL</td><td>SPECIMEN</td><td></td><td></td><td></td><td></td></tr>
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