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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **BJC HealthCare – Entity Abbreviation** | | | | | | | | | **(firm-TBD)** | | | | | |
| Entity Name | | | | | | | | | (firm) Project No. xxx | | | | | |
| Project Name | | | | | | | | | BJC Project No. 15Cxxx | | | | | |
|  | | | | | | | | | Date | | | | | |
|  | | | | | | | | | | | | | | |
| **Functional Program** | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **Description of Services/Model of Care:** | | | | | | | | | | | | | | |
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| **Existing and Proposed Location:** | | | | | | | | | | | | | | |
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| **Patient Population:** | | | | | | | | | | | | | | |
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| **Current Volumes vs. Projected Volumes (including assumptions):** | | | | | | | | | | | | | | |
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| **Hours of Operation/Shifts/Visiting Hours:** | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
|  | | | Mon. | | Tues. | Wed. | | Thurs. | | | Fri. | | Sat. | Sun. |
|  | | |  | |  |  | |  | | |  | |  |  |
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| **Number of Staff per Shift and Job Descriptions:** | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **Based on Busiest Shift:** | | | | | | | | | | | | | | |
| Name | | | | Title | | | Computer Use - % of Shift | | | | | Dedicated or Touch-Down? | | |
| Departmental Staff | | | | | | | | | | | | | | |
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|  | | | |  | | |  | | | | |  | | |
|  | | | |  | | |  | | | | |  | | |
| Ancillary Staff | | | | | | | | | | | | | | |
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| **Circulation / Flow:** | | | | | | | | | | | | | | |
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|  | | Patient: | | | | | | | | | | | | |
|  | |  | | | | | | | | | | | | |
|  | | Visitor: | | | | | | | | | | | | |
|  | |  | | | | | | | | | | | | |
|  | | Nurse: | | | | | | | | | | | | |
|  | |  | | | | | | | | | | | | |
|  | | Physician/Resident: | | | | | | | | | | | | |
|  | |  | | | | | | | | | | | | |
|  | | Ancillary Staff (i.e. Dietary, PT, RT, Lab, Pharmacy, Imaging, Etc.): | | | | | | | | | | | | |
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|  | | Materials Management/House Keeping/Materials/Supplies/Soiled: | | | | | | | | | | | | |
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| **Key Adjacencies:** | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
|  | | Internal: | | | | | | | | | | | | |
|  | |  | | | | | | | | | | | | |
|  | | External: | | | | | | | | | | | | |
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| **Communication/Information Systems:** | | | | | | | | | | | | | | |
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| Identify any of the following specialty equipment/software which will be required: | | | | | | | | | | | | | | |
| Vocera/Spectralink  Cisco wireless VOIP Phones:  Cell Phone (business use):  Video Conferencing:  Patient Touch Technology (PTT):  Applications (SIS, Metavision, Provation, Mosaiq, Cerner, Dictation, HCLL, etc.): | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **Education or Training Initiatives:** | | | | | | | | | | | | | | |
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| **Anticipated Changes/Trends:** | | | | | | | | | | | | | | |
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|  | New Services or Expansion of Existing Services | | | | | | | | | | | | | |
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|  | Changes in Healthcare Delivery or Technology | | | | | | | | | | | | | |
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| **Additional Design Criteria/Considerations:** | | | | | | | | | | | | | | |
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| This document represents the agreement on the functional information provided by you: | | | | | | | | | | | | | | |
| Sign: | | | | | | | | | | Date: | | | | |
| Sign: | | | | | | | | | | Date: | | | | |
| Administrator: | | | | | | | | | | Date: | | | | |