

PLANNING, DESIGN AND CONSTRUCTION

SPACE ALLOCATION/ALTERATION REQUEST/AUTHORIZATION FORM



UNIVERSITY
MEDICAL CENTER
OF EL PASO

Use this form to request space changes (ie. change of existing space, new space, expansions, reductions and/or relocations). You may require a cost center for expenses. Please note that any request for new furniture can take 6-8 wks on average for delivery unless an alternative and/or temporary solution can be provided. Save and maintain a copy of the completed form for your records.

CONTACT INFORMATION

Requesting Department/Point of Contact:

First Name **Jeannie**
Last Name **Shah** *request #2*
E-Mail Address **jeannie.shah@elpasochildren**

Budget

Department **EPCH Operating Room**
Title/Position **Associate Administrator**
Cost Center **70660**

SPACE REQUIREMENTS

What type of space are you requesting?

Administrative/Office ☐ Clinical/Service Instruction/Research ☐ Storage ☒ Other (Please specify below)

Alteration of current space needed? **Yes** ☒ **No** ☐ **NICU Procedure Room**

Allocation of new space needed? **Yes** ☐ **No** ☒

Describe why new/additional space is needed. Attach supporting documents if appropriate.
Address the implications to your program/service if additional space is not approved.

NICU patients have bedside procedures in the NICU pods. NICU intensivist, surgeons and IR proceduralist need a dedicated area to safely perform procedures within the department outside of the pods. The dedicated procedure room does not have the ability to increase temperature or modify the humidity and does not have positive pressure.

Date space will be needed: **As soon as possible**

How many individuals will be assigned to this space. (Specify full-time or part time for each space requested.)

Full time for all Operating room? NICU staff, anesthesia and physicians

Do you have a space in mind? If so, why is this space adequate? Who and what is currently there?

NICU procedure room. This room is inside the NICU, has an overhead OR light and anesthesia machine.

What attempts have been made to locate space within your current space allocation? Has under utilized space been assessed to solve this need? Have shared space possibilities been explored?

SPACE REQUIREMENTS CONTINUED

If space will be vacated by approval of this request, please indicated if current space will be released or describe the space backfill proposal.

Not applicable

Facility needs (Please indicate any electrical, HVAC, storage, plumbing, etc.). IT needs: be specific (how many outlet/data ports in each room needed.)

HVAC, steam

Furniture needs: Does any new furniture need to be purchased? if relocating, what furniture will be transferred to new space?

Not applicable

Provide information on any time constraints that may affect the timing of allocation of the space.

REQUEST TO CHANGE FUNCTION OF SPACE (IF APPLICABLE)

Building & Room Number: EPCH NICU Procure room

Current Room Type: Procedure Room

Requested Room Type Change: No changes

Justification for Change: Dedicated area for bedside procedures within NICU

Will this require a State Application? (see below)

An application is required for construction, erection, repair, remodeling, renovations, modifications, additions, alterations, removal, conversion, change of service(s), change of function, change of licensed beds or ESRD stations, change of licensed facility type, large/stationary equipment replacement, building system equipment upgrade, demolition, initial facility license or re-opening a closed General or Special Hospital, Private Psychiatric Hospital or Crisis Stabilization Unit, Ambulatory Surgical Center, End Stage Renal Disease Facility, Freestanding Emergency Medical Care Facility, or Special Care Facility.

AUTHORIZATION SIGNATURES**Chief Operating Officer:****Comments:****Assistant Administrator of Planning, Design & Construction:****Comments:****Assistant Administrator of Facilities:****Comments:****Approving Supervisor of Applicant's Department:**