CONSTRUCTION NEEDS ASSESSMENT QUESTIONNAIRE
PRELIMINARY EVALUATION FOR NEW CONSTRUCTION OR CHANGE OF USE

This questionnaire is intended for use as a preliminary tool in determining the needs of a new or change-of-use space that will be constructed, renovated, retrofitted and/or receive new equipment.
This form is a tool to help determine a facility's need for a new use or change in use of a space that will be constructed, renovated, or retrofitted.

This questionnaire has been created as a tool for use by the industry and is not the official position of the NBBJ, FGI (Facilities Guidelines Insitute), HGRC (Healthcare Guidelines Review Committee), AIA AAH (AIA Academy of Architecture for Health), or ACHA (American College of Healthcare Architects).

INSTRUCTIONS:
Please use this form to describe the anticipated space (i.e., a new space, changes to an existing space, an expansion, or reductions and/or relocations).

A Individual Information

Name/Contact		Telephone	
Title		Email	
Department			

B Background. *Describe the need or request for the new or changed space use, briefly. If the space is existing (e.g., designated for temporary use, change of use, change of equipment), identify the space here (location, department, floor, room number).*

Select all that apply.

- ☐ Temporary space
- ☐ Existing space, same use
- ☐ Existing space, change of use
- ☐ New space, new use
- ☐ Equipment new
- ☐ Equipment upgrade/replacement
- ☐ Clinical/patient contact
- ☐ Highly-specialized suite (e.g., OR, shielding, secured area)

C Contemplated Activities. *Briefly describe the types of examinations or procedures expected to be performed in this space. List separately procedures or technology advancements the health care organization may want to consider in the future (e.g., cases of increasing complexity, possibility of acquiring new equipment, known or predicted advancements in technology, new types of procedures based on intended recruitment).*

D Level of risk. *If patient care will be delivered in the space, please identify as best you can the perceived level of risk to the patient as indicated by:*

- ☐ Non-invasive (e.g., exam, consult, diagnostic, needle/bloodwork, IV contrast, low to no risk of infection)
- ☐ > Non-invasive < Invasive (i.e., percutaneous or minimally invasive procedures)
- ☐ Invasive (e.g., open surgical case; *see FGI definition of "invasive procedure" below*)

Invasive Procedure (definition per FGI *Guidelines* glossary, 2018 edition):
A procedure that is performed in an aseptic surgical field and penetrates the protective surfaces of a patient's body (e.g., subcutaneous tissue, mucous membranes, cornea). An invasive procedure may fall into one or more of the following categories:

- Requires entry into or opening of a sterile body cavity (i.e., cranium, chest, abdomen, pelvis, joint spaces)
- Involves insertion of an indwelling foreign body
- Includes excision and grafting of burns that cover more than 20 percent of total body area
- Does not begin as an open procedure but has a recognized measurable risk of requiring conversion to an open procedure

List other information on patient population (e.g., general characteristics [age, gender], physical limitations and considerations, co-morbidities).

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E **Anesthetic.** *If patient sedation is involved, please identify as best you can the need for sedation and type of sedation.*

- ☐ No sedation is required.
- ☐ Sedation required to perform procedure
- ☐ Sedation required by type of patient (e.g., pediatric, anxious)
- ☐ Sedation other than anesthetic gas or inhalation anesthetic
- ☐ Sedation by anesthetic gas/inhalation anesthetic
- ☐ Patient will require physiological monitoring
- ☐ Patient is anticipated to require active life support

F **Type of setting.** *Identify all that apply.*

- ☐ Hospital/inpatient
- ☐ Freestanding/ambulatory/outpatient
- ☐ Emergency room
- ☐
- ☐ Examination, treatment, consultation, or Class 1 imaging room
- ☐ Procedure or Class 2 imaging room
- ☐ Operating or Class 3 imaging room

Does the new space have special requirements (e.g., infrastructure [structural/ventilation/plumbing/electrical], shielding, medical gas outlets, acoustical, flooring, pressurization, location, visibility, access, adjacencies, relationships to other programs, number of staff required, limited access etc.)?

G **Location Information.** *If multiple locations are involved, please fill out a separate form for each location.*

from Current location Building ☐ Floor ☐

to Preferred location Building ☐ Floor ☐

H **Other Information.** *For renovation, expansion, and backfill projects, briefly describe why your existing space is inadequate.*

If space will be vacated, please indicate if current space will be released by the department or describe the space backfill proposal.

Additional comments

I **Requested by:**

Name:
Title:
Date:
Signature: ☐