

	ID: Form - 7604599921	Doc No: HS00-3-160
	Email: sbsadministration@HealthShare.health.nsw.gov.au	
Date Published: 9-Mar-14	Applies to: All Food Services	Approver: QAF
Author: Fifi Spechler	Modified: 31-Oct-24	Version: 4.0

FM REQUEST FOR CHANGE OF SERVICE

1. Request must be completed in full and signed off by the local Health Service Manager.
2. Requests for Service amendments should be submitted 8 weeks in advance to enable resourcing issues and finalisation of adjustments to be assessed, negotiated and agreed upon, except in urgent or critical cases.
3. HealthShare (HS) will confirm receipt of request and initiate any clarification matters with the person submitting the form, except in the case of major proposals. HS would aim to have responses provided with the 4 week time frame. Relatively simple proposals would be responded to as soon as practical.

SECTION 1 - PROPOSED SERVICE CHANGE DETAILS (TO BE COMPLETED BY LHD)

REQUEST FOR CHANGE OF SERVICE	
Hospital/LHD	Goulburn SNSWLHD
Cost Centre Name	Goulburn Renal Unit
Cost Centre Number	935016
Name of Requestor	Tracy Sampson
Position Title	Goulburn Nurse Unit Manager
Telephone Number	0248254633
Email address	Tracy.sampson@health.nsw.gov.au
Proposed Service Commence Date	Monday 9 th December 2024

TYPE OF SERVICE (TICK THE APPROPRIATE BOX)

<input type="checkbox"/>	New Service	<input checked="" type="checkbox"/>	Amended Service	<input type="checkbox"/>	Reduced Service
<input checked="" type="checkbox"/>	Food Services	<input checked="" type="checkbox"/>	Cleaning	<input checked="" type="checkbox"/>	Linen
<input checked="" type="checkbox"/>	Security	<input type="checkbox"/>	Others: Stores		

DETAILS OF PROPOSED SERVICE CHANGE REQUEST

❖ Includes: existing services, service gaps, additions, improvements required and expected frequency.
 Attach supporting documentation as applicable. (Consultation with Dietitians, Speech Therapist & Infection Control if required)

Currently the Goulburn Dialysis Unit operates 0700 – 1500hours Monday to Saturday each week, with 9 patients on each shift.


The proposal is to open an additional shift commencing Monday 9th December 2024.

The shift will operate 1300 – 2100 Mondays , Wednesdays and Fridays .

The service will cater up to an additional 8 consumers with two staff being in the unit after business hours .

The increase in service will require a change to cleaning, security and catering services

Additional Sandwiches will need to be provided.

Proposal submitted by Health Service Manager			
<input checked="" type="checkbox"/>	YES	<input checked="" type="checkbox"/>	NO
Comment:			
Name	Jodie Mitchell		
Position Title	Renal Nurse Manager SNSWLHD		
Telephone Number	0498846176		
Email address	Jodie.mitchell@health.nsw.gov.au		
Signature		Date	31.10.2024

SECTION 2 – HS RESPONSE (TO BE COMPLETED BY HEALTHSHARE)

FOOD SERVICE BED CATEGORY (TICK THE CORRECT BOX)

UNIT PRICING SITE (>50 BEDS)	<input type="checkbox"/>	YES , Bed change Number:	<input type="checkbox"/>	NO
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❖ **Note: Patient Food Services bed count 50 or greater is charged at 'hospital category' unit price per meal category as per Health Share Unit pricing Guide.**

FIXED PRICING SITE (<50 BEDS)	<input type="checkbox"/>	YES , Bed Change Number:	<input type="checkbox"/>	NO , Pass through site (Special purpose hospital such as Mental Health/Children)
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❖ **Note: Fixed Pricing and Pass Through sites please compute 2.1 and 2.2 below.**

2.1 TRANSITION/INITIAL COSTS (IF APPLICABLE)	
Calculation details attached as appendix : <input type="checkbox"/> YES <input type="checkbox"/> NO	

2.2 ONGOING COSTS (FIXED PRICE OR PASS THROUGH HOSPITALS)	
a. Salaries	
b. Goods (Consumables)	
c. RMR	
d. Other	
Total (a+b+c+d):	

Calculation details attached as appendix : <input type="checkbox"/> YES <input type="checkbox"/> NO	
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PREPARED BY HS SECTOR MANAGER			
Approved	<input type="checkbox"/>	YES	<input type="checkbox"/> NO
Comments:			
Name			
Telephone number			
Email address			
Signature		Date	

COST REVIEWED BY HS FINANCE MANAGER			
Approved	<input type="checkbox"/>	YES	<input type="checkbox"/> NO
Name			
Telephone number			
Email address			
Signature		Date	

APPROVED BY HS REGIONAL MANAGER			
Approved	<input type="checkbox"/>	YES	<input type="checkbox"/> NO
Comments:			
Name			
Telephone Number			
Email address			
Signature		Date	

SECTION 3 – FINAL APPROVAL BY LHD EXECUTIVE

PROPOSAL SUBMITTED TO LHD EXECUTIVE REPRESENTATIVE			
Approved	<input type="checkbox"/>	YES	<input type="checkbox"/> NO
Comments			
Name			
Position Title			
Telephone number			
Email address			
Signature		Date	

SECTION 4 – HS RECORD (FOR HS USE ONLY)

FINAL LHD SIGNED COPY CIRCULATED TO HS FINANCE: YES

SCOPE OF SERVICE UPDATED ON "W" DRIVE : YES