

## The Health Television System PRE-INSTALLATION SURVEY

The Health Television System (HTS) is the first national educational television network for Hospital patients. Broadcast to patient bedsides, our programming service provides playback equipment, installation, and maintenance to the Hospital.

Your Hospital medical and nursing staff is considering adding the HTS to your TV system. Completing this survey and returning it to us now will help us plan for your installation and assure your Hospital a place on the priority installation list.

Completing this survey does not obligate your Hospital in any way. Installation of HTS will not take place until the HTS's Contract is signed by an administrative officer of your institution and returned to The Health Television System Inc (HTS Inc).

HTS equipment will consist of video playback equipment, timer controller, and channel modulator, in an equipment rack approximately 54" x 24" x 24".

The HTS equipment can be located in one of two areas: (a) close to the headend of the main system if the channel is to be viewed over the entire system, or (b) close to the point where the main system splits off to feed the patients' wing, if the program is to be viewed only in specific areas.

Please contact the HTS Inc engineering group at (716)-662-6759 by fax if you have any questions in this area. Thank you for your time.

Name and Address of Your Hospital:

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1 Where will the HTS equipment be located?

Building: \_\_\_\_\_

Floor: \_\_\_\_\_ Room #: \_\_\_\_\_

2a Is this where the existing TV headend is located?

Yes \_\_\_\_\_ NO \_\_\_\_\_\*

2b If not, please specify the exact headend location (or point we to connect to)

Building: \_\_\_\_\_

Floor: \_\_\_\_\_ Room #: \_\_\_\_\_

\*Estimated distance to headend or point we have to connect to? \_\_\_\_\_

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2c Is there a need for a special cable conduit to connect the HTS equipment to the system feed point?

Yes \_\_\_\_\_ NO \_\_\_\_\_

The Hospital Agreement provides that the Hospital will supply and install the following (asterisk\*) items required for the successful, automated operation of the HTS system, prior to installation of the HTS equipment. ***Should any of the following indicate a NO response, the Hospital agrees to ensure these resources are requisitioned, supplied and installed prior to delivery of the HTS equipment:***

**3\*** Is there currently available, in the room where the HTS equipment will be installed, a **TV set connected to the main cable system** available for use during installation and maintenance?

Yes \_\_\_\_\_ NO \_\_\_\_\_

**3a\*** Is there currently available, in the room where the HTS equipment will be installed, a **telephone line (direct in)** and extension circuit available to be used by HTS to call into the equipment at our own expense to maintain its operation? (**two channels require one telephone line**)

Yes \_\_\_\_\_ NO \_\_\_\_\_

**4\*** Is there currently available, in the room where the HTS equipment will be installed, an existing **isolated AC outlet** to connect the HTS equipment to the Hospital's electrical system? HTS will require one **120 volt, 15 amp U-ground receptacle on its own breaker** near the rear bottom or top of the supplied cabinet. (**two channels require two outlets in single receptacle**)

Yes \_\_\_\_\_ NO \_\_\_\_\_

**4b\*** Is this **power outlet always on** i.e. not switched off for back up power tests or at any time except major utility failure? Please check with building maintenance. The HTS system should remain **powered at all times**.

On at all times \_\_\_\_\_ Sometimes switched off \_\_\_\_\_

5a How many beds are there in the designated patient areas? \_\_\_\_\_

**5b\*** **A television set is required by each patient's bedside.** Will the Hospital have to add televisions to meet this criteria?

Yes \_\_\_\_\_ NO \_\_\_\_\_ If Yes, how many televisions to add \_\_\_\_\_

**6a\*** What channel(s) do you anticipate using for Healthtv \_\_\_\_\_ Parent Channel \_\_\_\_\_

6b Are there alternate channel choices for Healthtv \_\_\_\_\_ Parent Channel \_\_\_\_\_

**6c\*** Will the Hospital need to notch out an existing channel?

Yes \_\_\_\_\_ NO \_\_\_\_\_

**6d\*** Do any TV's in the Hospital require **adjustment, modifications or lockout removal** to view HTS?

Yes \_\_\_\_\_ NO \_\_\_\_\_

## HTS PRE-INSTALLATION SURVEY

- 7 Is your TV system connected to the local cable system?  
Yes \_\_\_\_\_ NO \_\_\_\_\_
- 8 Does your Hospital own its TV sets?  
Yes \_\_\_\_\_ NO \_\_\_\_\_ If not, please complete below  
Company name \_\_\_\_\_  
Contact name \_\_\_\_\_ Phone \_\_\_\_\_
- 9 Does your Hospital own its master television cable system?  
Yes \_\_\_\_\_ NO \_\_\_\_\_ If not, please complete below  
Company name \_\_\_\_\_  
Contact name \_\_\_\_\_ Phone \_\_\_\_\_
- 9a Can the person who maintains the Hospital's cable system be made available during the installation of HTS? Yes \_\_\_\_\_ NO \_\_\_\_\_
- 10 Who services your TV distribution system?  
Company name \_\_\_\_\_  
Contact name \_\_\_\_\_ Phone \_\_\_\_\_
- 11 Who will be responsible for making arrangements for HTS to obtain access to the master television cable system?  
Contact name \_\_\_\_\_ Phone \_\_\_\_\_
- 12 Please provide the exact address for shipping the HTS equipment. This shipment will be a single box approximately 24" x 24" x 60" that weighs approximately 150 lbs. Please indicate all relevant details such as contact name, department or box number, etc.
- Shipping Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 13 Whom shall we contact to verify that the shipment has arrived?  
Contact: \_\_\_\_\_  
Phone \_\_\_\_\_

## HTS PRE-INSTALLATION SURVEY

13a Upon receipt from HTS Inc., the Hospital agrees to arrange to have the equipment moved, at an agreed upon time prior to installation, from the Hospital Receiving Department to the designated location

Yes \_\_\_\_\_

14 Is there any additional technical information that can be provided at this time, as we prepare for your installation?

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### TECHNICAL CONTACT

We require the name of the person who will be our primary contact for all technical matters regarding the HTS installation and maintenance. That person will be:

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone Number: \_(\_\_\_\_\_)\_\_\_\_\_

Fax Number: \_(\_\_\_\_\_)\_\_\_\_\_

Thank you for your assistance. Please return this pre-installation survey to:

Mr. Lane Steinhauer, V.P. Technical Services  
The Health Television System Inc  
3959 North Buffalo Road  
Orchard Park, NY 14127  
Phone: (877)-259-4111 Fax: (716)-662-6759

# *The Health Television System Inc*

## BASIC DATA

### PRIMARY CONTACT

To install the HTS and provide its various services, we will likely be working with a number of people on your Hospital's staff. It would be very helpful, however, if one individual could be designated as the primary contact person for all administrative matters pertaining to the HTS.

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

### PROGRAM GUIDES

To whom should the HTS program guides be sent?

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Mailing Address (if different than above):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

*The Health Television System Inc*

COUNT OF PATIENTS AND TV SETS

Number of patients annually: \_\_\_\_\_

Total number of hospital beds \_\_\_\_\_

UNIT (floor)	SERVICE (cardiology, oncology, GI, etc)	# OF BEDS	# OF TV SETS
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

TV sets serving staff areas \_\_\_\_\_

TV sets serving visitor lounges, waiting areas, clinics. \_\_\_\_\_

INFORMATION PROVIDED BY:

Name \_\_\_\_\_

Title \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_

Fax (\_\_\_\_\_) \_\_\_\_\_

e-mail \_\_\_\_\_

Date \_\_\_\_\_

MAIL OR FAX WITHIN ONE WEEK OF RECEIPT TO:

Ms. Kelly Morgan                      Fax: (716)-662-6759  
Administration Manager  
The Health Television System Inc  
3959 North Buffalo Road  
Orchard Park, NY 14127

THE PARENT CHANNEL®

COUNT OF OB UNIT POSTPARTUM BEDS AND TV SETS

HOSPITAL: \_\_\_\_\_

CITY/STATE: \_\_\_\_\_

NUMBER OF POSTPARTUM BEDS IN OB UNIT: \_\_\_\_\_

Do include LDRP beds used for postpartum.  
Do not include Labor, LD, or LDR beds not used for postpartum  
Do not include non-OB unit beds used for OB overflow.

NUMBER OF TV SETS SERVING THE BEDS ABOVE: \_\_\_\_\_

Only include TV sets serving patient beds.  
Do not include TV sets serving staff areas.  
Do not include TV sets serving visitor lounges and/or waiting areas.

INFORMATION PROVIDED BY: \_\_\_\_\_

(name)

\_\_\_\_\_  
(title)

(\_\_\_\_\_) \_\_\_\_\_

(phone)

\_\_\_\_\_  
(date)

MAIL OR FAX WITHIN ONE WEEK OF RECEIPT TO:

Ms. Kelly Morgan                      Fax: (716)-662-6759  
Administration Manager  
The Health Television System Inc  
3959 North Buffalo Road  
Orchard Park, NY 14127