

Splashes of Hope
Building Assessment / Site Visit form

Site Visit Date: _____

Hospital: _____

Address: _____

Contact's Info: E-Mail: _____ Phone: _____

Project's Location: _____

Unit: _____ Floor: _____

Attended By: _____

Age group of patients: _____ Type of Patients _____

Procedures performed in designated area to be splashed:

Existing Color of Space: _____

Theme of mural: _____

Specific elements or focal points to incorporate into the composition for maximum therapeutic value: _____

Any figures? _____ Children? _____ Families? _____ Animals? _____

Any cultural diversity _____

Style: Impressionistic _____ Realistic _____ Cartoon or Animated _____

WALL _____ or **Masonite Board** _____ Dimensions to be splashed:

1) _____ W. _____ H. Designated Area _____

Theme: _____

2) _____ W. _____ H. Name of Area: _____

Theme: _____

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3) _____ W. _____ H. Name of Area: _____

Theme: _____

4) _____ W. _____ H. Name of Area: _____

Theme: _____

5) _____ W. _____ H. Name of Area: _____

Theme: _____

Focal Points

Theme _____

1) _____ W. _____ H. Location: _____

2) _____ W. _____ H. Location: _____

3) _____ W. _____ H. Location: _____

Paint on Site: _____ **Paint on Masonite Board:** _____

Number of Ceiling Tiles to be splashed: _____ 2'x2' (Square) _____ 2'x4' (rectangular)

If rectangular, when viewed from below is the tile _____ Horizontal or _____ Vertical

Theme of Ceiling Tiles: _____

Custom Coloring Books for visiting children: _____

Follow- Up meeting scheduled for: _____ **Meeting with** _____

Does the facility have:

Allocated funds for this project? _____

A possible sponsor for this project? _____

An in-house grant writer we can work with? _____

Will the hospital match funds if we secure a grant? _____