Patient and Family Advisor Application Form

Name (First and Last):				
Street Address:				
City:	State:		ZIP Code:	
Home phone:	Cell phone:		Email address:	
Preferred contact (circle one):	Home phone	Cell phone	Email	
The following questi	ons will help	us get to k	now you better.	
1. Are you a Patient				
Family member of a p	patient			
2. When was your care exp	erience at this hosp	oital/clinic? (Checl	c all that apply.)	
□ 2016□ 2015				
2014				
2013 or before				
3. What language(s) do yo	u speak?			



4.	Which unit(s) provided care for you or your family member: (check all that apply)				
	Hospital Emergency Department				
	☐ Hospital Inpatient Services				
	☐ Hospital Outpatient Services				
	Shenandoah Physicians Clinic—Shenandoah or Sidney Location				
	☐ Shenandoah Specialty Physicians				
	☐ Wellness Center				
5.	5. We recognize that our patient and family advisors have busy lives. How much time are you able to commit t being a patient and family advisor? (Check one)				
	Less than 1 hour per month	3 to 4 hours per month			
	1 to 2 hours per month	☐ More than 4 hours per month			
0.	Are you available to serve as an advisor for at least (You can still be an advisor if you answer "no.") Yes No	1 to 2 years.			
7.	7. How do you want to help? I want to: (Check all of your interest areas)				
	Serve as a member of the patient and family advisory council. Potential advisory council members should be ready to commit to serving on the council for at least 1 to 2 years. The advisory council meets once every two months for 1 hour from 5:30 to 6:30 pm. A meal will be served.	Review procedures and provide input to improve the hospital and clinic processes.			
		Provide input as we implement bedside shift report, where nurses who are going off duty share information with nurses coming on duty at the patient's bedside.			
	Help develop or review informational materials for patients and family members.	Review procedures and provide input to improve transitions in care (for example, between hospital units or discharge from hospital to home).			
	Help improve patient safety and the prevention of medical errors.	Other issues (please describe):			
	Help improve the patient and family role in care decision making.				

Please tell us about yourself.

8.	Why do you want to become a patient and family advisor?
9.	Please briefly describe any experience you may have as an advisor, as an active volunteer, or as a public speaker.
10.	Please describe any specific things that doctors or hospital/clinic staff did or said while you or your family member were receiving services that were helpful to you or your family.
11.	Please describe any specific things that doctors and hospital/clinic staff could have done differently to be more helpful while you or your family member were receiving services.
12.	Our patient and family advisors reflect the diversity of the patients and families we serve. Please share anything about yourself that you think would add to the diversity of our team of advisors.
	ease return this form to: Sue Hanna, RN. E-mail <u>shanna@smchospital.com</u> or fax 712-246-7340. Mailing address Shenandoah Physicians Clinic, One Jack Foster Dr., Shenandoah, IA 51601.