

To be completed by staff:

Will your volunteer have contact with patients? Yes \_\_\_ No \_\_\_

Please identify your PFAC (e.g. Adult, Peds, Oncology, ED, Ambulatory, etc.): \_\_\_\_\_

Date Received: \_\_\_\_\_



CHILDREN'S  
HOSPITAL

## APPLICATION FOR PATIENT AND FAMILY ADVISORS

*Please Print:*

**Name:** \_\_\_\_\_  
(Last) (First) (MI)

**Address:** \_\_\_\_\_

**City, State, Zip Code:** \_\_\_\_\_

**Home Phone:** (10 digits) \_\_\_\_\_ **Cell Phone:** (10 digits) \_\_\_\_\_

**Work Phone:** (10 digits) \_\_\_\_\_

**E-mail Address:** \_\_\_\_\_

**Emergency Contact name and phone:** \_\_\_\_\_

**Language(s) You Speak:** \_\_\_\_\_

**Will you allow your contact information to be shared with other committee/advisory council members?** Yes  No

**I am/was:** A patient  A family member of a patient

**My care is/was provided by** \_\_\_\_\_ : (check all that apply)  
(Department/Doctor)

- |  |   |
|--|---|
| <input type="checkbox"/> Hospitalization (inpatient)   | <input type="checkbox"/> Emergency Department Care                |
| <input type="checkbox"/> Clinic visit (outpatient)     | <input type="checkbox"/> Other programs, departments, or services |
| <input type="checkbox"/> Both inpatient and outpatient |   |

**The dates of my active care experience at CHNOLA include:** (check all that apply)

- Within the past 5 years  More than 5 years ago  More than 10 years ago

**Within the past two years, what care services have you or your family member used?** (check any that apply). We are looking to our Council members to have a diversity of experience with Children's Hospital, and appreciate your sharing any information. Please be assured that this information is private and will be maintained as CONFIDENTIAL.

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Auto-immune                 | <input type="checkbox"/> Gastroenterology/GI           | <input type="checkbox"/> Orthopedic                  |
| <input type="checkbox"/> Blood and Lymphatic Defects | <input type="checkbox"/> Genetics and or Birth Defects | <input type="checkbox"/> Rehabilitation              |
| <input type="checkbox"/> Cancer                      | <input type="checkbox"/> Intensive Care Unit (ICU)     | <input type="checkbox"/> Skin and Connective Tissues |
| <input type="checkbox"/> Cardiology                  | <input type="checkbox"/> Infectious Disease            | <input type="checkbox"/> Transplant                  |
| <input type="checkbox"/> Chest/Pulmonary             | <input type="checkbox"/> Mental Health                 | <input type="checkbox"/> Surgery                     |
| <input type="checkbox"/> Ear, Nose and Throat        | <input type="checkbox"/> Nephrology/Kidney             | <input type="checkbox"/> Urology                     |
| <input type="checkbox"/> Endocrinology/Diabetes      | <input type="checkbox"/> Neurology/Neurosurgery        | <input type="checkbox"/> Other                       |
| <input type="checkbox"/> Eye                         | <input type="checkbox"/> Nutrition                     |  |

**Times when you are able to engage in PFAC work:** (check all that apply)

- Daytime       Evening       Weekend

**I would be interested in helping with (identify all of your interest areas):**

- Developing/reviewing educational materials to improve the patient and family experience.
- Planning for the hospitalization (inpatient) care experience for children.
- Planning for the emergency care experience.
- Planning for the clinic (outpatient and ambulatory) care experience.
- Planning for the oncology care experience.
- Planning the design of systems of care and facilities for the emergency experience.
- Educating medical students and residents, new employees, and other staff about the experience of care and effective communication support.
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- Participating in facility design planning.
- Improving the coordination of care and the transition to home and community care.
- Issues of special interest (please describe):

**Why would you like to serve as an advisor?**

**If you have served as an advisor, been an active volunteer committee member, or done public speaking for other programs or organizations, please briefly describe this experience:**

**Tell us about your or your family's healthcare experience at Children's. What would you have improved about this experience? What impressed you about this experience?**

**Is there anything that you would like us to know?**

**Do you know other individuals and/or families who have experienced care at Children's who might be interested in serving as advisors? Please call them for us or list their name(s) and phone number(s) here:**

*Please return this form to:*

Michele Borey, Director of Patient Experience  
Children's Hospital  
200 Henry Clay Avenue  
New Orleans, LA 70118  
504-896-3073