Children's Hospital
New Orleans LCMC Health

APPLICATION FOR PATIENT AND FAMILY COUNCIL

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)

☐ Hospitalization (inpatient)
☐ Emergency Department Care
☐ Clinic visit (outpatient)
☐ Other programs, departments, or services
☐ 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.

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

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 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.

☐ 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 a Children's Hospital Patient and Family Advisory Council member?

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 Hospital. 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 Hospital 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:
Patient Experience
200 Henry Clay Avenue
New Orleans, LA 70118

To be completed by staff:
Will your volunteer have contact with patients? Yes_____No_____
Please identify your PFAC (e.g. General Hospital, Cardiology, Pulmonary (ENT, Trach):

Date Received: _____