OB Patient and Family Advisory Council

Name (First and Last):

Street Address:

City: State: Zip Code:

Home Phone: Cell Phone:

Email Address:

Preferred contact (check one):

- ☐ Home Phone
- ☐ Cell Phone
- ☐ Email

The following questions will help us get to know you better.

1. Are you a:

- ☐ Patient
- ☐ Family member of a patient

2. When was your care experience at MDH? (Check all that apply.)

- ☐ 2016 to current year
- ☐ 2015
- ☐ 2014
- ☐ 2013
- ☐ 2012 or before

3. What language(s) do you speak?

4. In the past three years, have you or your family member interacted with the following areas/departments during the time as an obstetrical patient: (check all that apply)

- ☐ Obstetrics Department
- ☐ MDH Obstetrics & Gynecology Clinic
- ☐ ER
- ☐ Lab
- ☐ Radiology
- ☐ Admitting

5. We recognize our patient and family advisors have busy lives. How much time are you able to commit to being a patient and family advisor? (Check one)

- ☐ Less than 1 hour per month
- ☐ 1 to 2 hours per month
- ☐ 3 to 4 hours per month
- ☐ More than 4 hours per month

6. Are you available to serve as an advisor for at least 1 year?

- ☐ Yes
- ☐ No

Please tell us about yourself.

7. Why do you want to become a patient and family advisor?

8. Do you volunteer in your community? If so, for which organizations?

9. Do you feel comfortable working in groups, speaking up and providing input?

10. In your OB experience what did we do well?

11. What could we have done better?

12. What would you like the hospital to learn from your experience in OB?

13. What are the areas you feel MDH OB has the most area for opportunity? (Check top 3 areas)

- ☐ Education during prenatal period
- ☐ Education during labor and deliver
- ☐ Education at discharge
- ☐ Keeping the patient/family informed
- ☐ Obstetrics & Gynecology Clinic
- ☐ Other issues (please describe)
- ☐ Appearance of Department
- ☐ Pain Management
- ☐ Care provided
- ☐ Communication
- ☐ Organization and Timeliness

Please provide details, if possible, about the chosen areas above:

14. Are there certain topics or areas in which you have a special interest?

As a Patient/Family Advisory Council member:

- I will be punctual and conscientious in the fulfillment of my duties and if for some reason I connot attend a meeting, I will notify the PFAC secretary.
- I will conduct myself with dignity, courtesy and consideration.
- I will consider all information as confidential.
- I will take any problems, criticism, or suggestions to the leader or staff liason.
- I will endeavor to make my work of the highest quality.
- I will uphold the standards, policies and values of MDH.
- I understand that attendance at meetings is necessary.

I certify that all statements on this application are true and complete. If selected for the committee membership, I understand that any falsification of, or mission from, this application may result in termination of membership from the Patient Advisory Council. I further understand:

- ☐ Council members are volunteers, therefore are required to complete general paperwork, including confidentiality agreement and background check.
- ☐ McDonough District Hospital is a smoke free campus.
- ☐ Selection if not made at the present time, may be considered in the future.

SIGNATURE: DATE:

Thank you for your interest in the OB Patient and Family Advisory Council!

Please return this form to:

Crystal Dobbs

525 East Grant Street

Macomb, IL 61455

or email to: cmdobbs@mdh.org

For questions call: (309) 836-1570