



Better Together

Health Services Patient Engagement Roadmap

Appendix 16

Application Form for Patient Representatives.

Full name			
Address:			
Street		City/County:	
Home phone:		Mobile phone:	
Email address:			

What is the best way to contact you? Please tick.

- | | |
|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> Home phone | <input type="checkbox"/> Mobile phone |
| <input type="checkbox"/> Email | <input type="checkbox"/> Post |

Help us get to know you better.

Please tick the box(es) that best describes your experience with healthcare services:

- | |
|--|
| <input type="checkbox"/> Patient currently accessing healthcare services |
| <input type="checkbox"/> Family member or carer of a patient |
| <input type="checkbox"/> Member of the public |

Where are you accessing healthcare services?

Name of hospital/ clinic/ community centre

What is your age-range?

- | | | |
|--------------------------------------|--|--------------------------------|
| <input type="checkbox"/> 18-29 | <input type="checkbox"/> 30-49 | <input type="checkbox"/> 50-74 |
| <input type="checkbox"/> 75 and Over | <input type="checkbox"/> Under 18 (parent/guardian consent will be required) | |

What language(s) do you speak?

Where did you hear about the opportunity to become a patient representative?

We understand that people have busy lives. How much time are you able to give to being a patient representative? (Tick one)

- | | |
|---|--|
| <input type="checkbox"/> Less than 1 hour per month | <input type="checkbox"/> 1 to 2 hours per month |
| <input type="checkbox"/> 3 to 4 hours per month | <input type="checkbox"/> More than 4 hours per month |

What day/s suit you best?

What time of the day suits you best?

When could you start as a patient representative?
Immediately: ☐ Yes ☐ No Preferred start date:



How long would you be able to commit to participating as a patient representative?

☐ Less than 1 year ☐ 1 year ☐ Unsure

Please tell us why you are interested in being a patient representative?

Do you have any experience as a member of a committee through work or as a volunteer?

If yes, please tell us a bit about the committee(s) and your role(s).

How do you think your experience and skills will help you as a patient representative?

Are there any areas within the healthcare journey that you are particularly interested in?

(e.g. prevention, screening, assessment, treatment or patient support)

Are there any particular healthcare conditions or groups accessing healthcare services you feel you best represent?

Please return this form to:

Example of Patient Experience Advisor Application Form:

Shared with permission by Mayo University Hospital

Patient Experience Advisors and Healthcare staff leading on the initiative

Mayo University Hospital Patient Experience Advisor Application form
Name of Applicant: _____
Address of Applicant: _____ _____
Telephone Number : _____
In the past 5 years have you or a member of your family used the services of Mayo University Hospital: Yes <input type="checkbox"/> No <input type="checkbox"/>
Why would you like to serve as an Advisor ? _____ _____ _____ _____
If you have served as an advocate, been an active volunteer, committee member or done public speaking for other programmes or organisations, please briefly describe this experience : _____ _____ _____ _____
<small>Mayo University Hospital Patient Experience Advisor Application Form Nov 2017</small>