Children's MINNESOTA

# FAMILY ADVISORY COUNCIL APPLICATION

Children's Hospitals and Clinics of Minnesota

*Please contact the Council if you have any questions or need this application in another form, i.e., Language, Braille, or Spoken Word*

**Voicemail: 612-813-7407 Email: familyadvisorycouncil@childrensmn.org**

**Today's date: _____**

1. **Your Name: _____**

2. **Home Address *(street, city, state, zip code):***

   **_____**

3. **Phone Number: Daytime: _____ Evening: _____**

4. **Email Address: _____**

5. Languages spoken in the home: _____

6. Occupation: _____

* ***Families who are recently bereaved are asked to wait two years after the death of their child before applying to the FAC.***

7. Name of child with health needs/experiences (if more than one child please add under question #9).

   _____ Child's DOB: _____ Relation to you: _____

8. Child's Primary Diagnosis: _____

9. Other Children? ☐ Yes (Please enter names and dates of birth.) ☐ No

   _____

   _____

10. What campus does your family primarily use? _____

    Has your family used other Children's locations? (Check all that apply.)
    ☐ Minneapolis ☐ St. Paul ☐ Minnetonka ☐ Roseville ☐ Maple Grove ☐ Woodwinds

    Has your family used a pediatric clinic aligned with Children's? (Check all that apply.)
    Metropolitan Pediatric Specialists: ☐ Edina ☐ Burnsville ☐ Shakopee
    Northeast Pediatric Clinic: ☐ Hugo
    PACE Clinic: ☐
    Partners in Pediatrics: ☐ Brooklyn Park ☐ St. Louis Park ☐ Maple Grove ☐ Plymouth ☐ Rogers
    Other: ☐ _____

11. Would you be able to make a commitment to attend a 2-hour meeting every month for a term of three years? ☐ Yes ☐ No

12. What medical services has your family used? (Check all that apply.) Check **Past Year** if you have used this service within the past year or **Ever** if you have ever used this service.

| Past Year | Ever | | Past Year | Ever | |
|---|---|---|---|---|---|
| ☐ | ☐ | Emergency Department | ☐ | ☐ | Hematology/Oncology |
| ☐ | ☐ | Inpatient Unit _____ | ☐ | ☐ | Home Care or Hospice |
| ☐ | ☐ | Neonatal ICU | ☐ | ☐ | Immunology |
| ☐ | ☐ | Pediatric ICU | ☐ | ☐ | Integrative Medicine |
| ☐ | ☐ | Day/Outpatient Surgery | ☐ | ☐ | Lab |
| ☐ | ☐ | Short Stay Unit (SSU) | ☐ | ☐ | Mother Baby (Mpls.) |
| ☐ | ☐ | Infant Care Center (ICC) | ☐ | ☐ | Nephrology |
| ☐ | ☐ | Special Care Nursery | ☐ | ☐ | Neurology |
| Specialty Services: | | | ☐ | ☐ | Neurosurgery |
| ☐ | ☐ | Adolescent Medicine | ☐ | ☐ | NICU follow up Clinic |
| ☐ | ☐ | Asthma/Allergy | ☐ | ☐ | Orthopedics |
| ☐ | ☐ | Audiology | ☐ | ☐ | Pain Team/Palliative Care |
| ☐ | ☐ | Autism | ☐ | ☐ | Pharmacy |
| ☐ | ☐ | Birth Center (St. Paul) | ☐ | ☐ | Psychiatry |
| ☐ | ☐ | Cardiology | ☐ | ☐ | Psychology |
| ☐ | ☐ | Cath Lab | ☐ | ☐ | Respiratory/Pulmonology |
| ☐ | ☐ | Cleft/Craniofacial Clinic | ☐ | ☐ | Radiology |
| ☐ | ☐ | Cystic Fibrosis Clinic | ☐ | ☐ | Sleep Lab/Clinic |
| ☐ | ☐ | Developmental Clinic | ☐ | ☐ | Special Diagnostics |
| ☐ | ☐ | Down Syndrome Clinic | ☐ | ☐ | Surgery |
| ☐ | ☐ | Ear, Nose and Throat | ☐ | ☐ | Trauma |
| ☐ | ☐ | Eating Disorders | ☐ | ☐ | Urology |
| ☐ | ☐ | Endocrine/Diabetes | ☐ | ☐ | Other: _____ |
| ☐ | ☐ | Epilepsy Clinic | Rehabilitation: | | |
| ☐ | ☐ | Feeding Clinic | ☐ | ☐ | Animal Assisted Therapy |
| ☐ | ☐ | Gastroenterology/ GI | ☐ | ☐ | Occupational Therapy |
| ☐ | ☐ | General Pediatric Clinic | ☐ | ☐ | Physical Therapy |
| ☐ | ☐ | Genetics | ☐ | ☐ | Speech/Language Therapy |

13. Have you used the following non-medical services? (Check all that apply.)

| | | |
|---|---|---|
| ☐ Bereavement Services | ☐ Ethics Consult | ☐ MyChildren's |
| ☐ Caring Bridge Web Site | ☐ Family Resource Center | ☐ Ronald McDonald House |
| ☐ Chaplaincy | ☐ Financial Counseling | ☐ Sibling Play |
| ☐ Child Life | ☐ Geek Squad | ☐ Social Work |
| ☐ Children's Web Page | ☐ Interpreter Services | ☐ Other_____ |

14. Please tell us how you learned about the Family Advisory Council?

_____

_____

15. Why are you interested in joining the Family Advisory Council?

_____

_____

_____

I acknowledge that I have provided accurate information to the best of my ability.

_____ _____

Applicant Signature Date

*Please send the completed application to:*
Family Advisory Council – Mail Stop 70-503
Children's Hospitals and Clinics of Minnesota
345 North Smith Avenue
St. Paul, MN 55102

*Updated 12/3/15*