Peterborough Regional Health Centre

Patient & Family Partner Application

PRHC
PATIENT AND FAMILY EXPERIENCE

To be eligible to be a Patient & Family Partner (PFP), you or a *family member must have had received care at Peterborough Regional Health Centre (PRHC) in the last five (5) years. This would include things like an inpatient stay, outpatient clinic visit or getting imaging done, etc.

**Family is determined by the patient and is not limited to blood ties.*

Have you or your family member received care at PRHC within the last five (5) years?

☐ Yes ☐ No *If yes, continue with application.*

Name:	Date of birth (DD/MM/YYYY):	Current or previous PRHC employee? ☐ Yes ☐ No
Street address:	City:	Postal Code:
E-mail address:	Phone number(s):	Preferred contact method: ☐ Phone ☐ Email

How did you hear about the Patient & Family Partner (PFP) program?

How would you like to be involved? Please check all interest areas:

☐ I would like to contribute virtually (by telephone or by email, for example, completing surveys or reviewing documents and providing feedback)

☐ I would like to attend in-person or virtually meetings to provide input on matters which affect the patient and family experience

☐ Other (please describe): ______________________________

Describe any skills, experience or training that you feel will be an asset in the role of being a Patient & Family Partner:

At PRHC, I have been a: ☐ Patient ☐ Family member/Care Partner of a patient

Within the past two years, what care services have you or your family member used that you wish to provide your input on? (For example: Emergency, Cancer Care, Diagnostic Imaging, Intensive Care (ICU), Palliative, etc.)

Please indicate times that you would be available for meetings (if applicable)

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning	☐	☐	☐	☐	☐	☐	☐
Afternoon	☐	☐	☐	☐	☐	☐	☐
Evening	☐	☐	☐	☐	☐	☐	☐

PRHC is committed to promoting equity, diversity, and inclusion. To help support this work, we strive to include diverse perspectives across our Patient and Family Partner Program. The following optional questions helps us understand the various perspectives and lived experiences applicants may provide and can be helpful to us in ensuring diverse perspectives and experiences are included. All information is confidential and will be reviewed by the Patient & Family Partner (PFP) Program Lead and Quality & Process Improvement Department.

Do you identify with any of the following statements? Please select all that apply.

- ☐ I do not wish to answer/Not Applicable
- ☐ I was born outside of Canada
- ☐ I identify as LGBTQ2S+
- ☐ I have experienced homelessness or housing insecurity
- ☐ I am working full-time
- ☐ I have dependents living in my home
- ☐ I have experienced addiction myself or as a close family member/friend living with addiction
- ☐ English is not my first language
- ☐ I am living with a disability and/or chronic illness

Which of the following best describes you? Please select all that apply.

- ☐ Arab, Middle Eastern or West Asian (e.g. Afghan, Egyptian, Iranian, Lebanese, Persian, Turkish, Kurdish, etc.)
- ☐ Black (e.g. African, Afro-Canadian, Afro Caribbean, etc.)
- ☐ East Asian (e.g. Chinese, Korean, Japanese, Taiwanese, etc.)
- ☐ Jewish
- ☐ Latin American (Hispanic or Latin American descent)
- ☐ South Asian (e.g. Bangladeshi, Indian, Indo-Caribbean, Pakistani, Sri Lankan, etc.)
- ☐ Southeast Asian (e.g. Filipino, Vietnamese, Cambodian, Thai, Indonesian, etc.)
- ☐ White (e.g. European descent)
- ☐ Indigenous decent (First Nations, Métis Inuk/Inuit)
- ☐ Another race/ethnic group (please specify): ____________________
- ☐ Do not know
- ☐ Prefer not to answer

We recognize that all patients and family members have diverse experiences. If there are other comments you wish to provide regarding your experiences, please outline them below:

Do you have any physical limitations, special needs, dietary preferences or allergies we should know about? ☐ Yes ☐ No If yes, please list:

ALL INFORMATION IS CONFIDENTIAL

I hereby certify that all information included in this application is true and complete.

Applicant's Signature: ____________________ Date (DD/MM/YYYY): ____________________

PLEASE RETURN THIS COMPLETED APPLICATION FORM TO:

Quality & Patient Partnerships Department
Peterborough Regional Health Centre, 1 Hospital Drive, Peterborough, ON, K9J 7C6
ptexperience@prhc.on.ca | 705-743-2121 x. 3083