BAPTIST HEALTH
MADISONVILLE

**Patient Advisory Council Profile Form** Date: _____

Name:_____
Mailing Address:_____
City:_____ State:_____ Zip:_____
Telephone:_____ E-mail address:_____

1. Have you or a family member received care at Baptist Health within the past 12-18 months? Y/N
   Area(s) where care was received (please check all that apply):

   ☐ Inpatient ☐ Emergency Department ☐ Outpatient
   ☐ Prime Care ☐ Outpatient Infusion (i.e. chemotherapy)

2. How can you draw upon your own experiences you had with Baptist Health or another facility, to help us improve the patient experience?

   _____

   _____

3. Where do you see the biggest opportunity for improvement at Baptist Health Madisonville?

   _____

   _____

4. Do you have any dietary needs we should be aware of? _____Yes _____No
   If "yes," please elaborate: _____

5. Do you have any special needs we need to be aware of? Explain:_____

   _____

*(Please return in the self-addressed, stamped envelope)*