BAPTIST HEALTH DEACONESS MADISONVILLE

Patient Family 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 Deaconess Madisonville within the past 12-18 months? Y/N Area(s) where care was received (please check all that apply):

☐ Inpatient ☐ Emergency Department ☐ Medical Group
☐ Urgent Care ☐ Outpatient Testing ☐ Outpatient Infusion (i.e. chemotherapy)

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

_____

_____

3. Where do you see the biggest opportunity for improvement at Baptist Health Deaconess 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: _____

_____

6. Were you ever employed at any of our locations? _____

_____

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